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**Biotransenergetica**  
**a transpersonal psychotherapy**  
**A description of BTE practices**  
**from a therapist and client perspective.**

**February 2015**

*To those, psychotherapists and clients  
that sharing their therapeutic process  
and personal and spiritual development  
made possible to realize this study.*

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## **ABSTRACT**

In Biotransenergetica (BTE), a transpersonal psychotherapy model developed in the 1980s by Lattuada, the uniqueness of self-experience is pivotal. In the therapeutic process inner experiences and felt sense are essential. These are contained in the concept of Transe. During the psychotherapy session the psychotherapist favors the creation of the Transe, a field, using mindfulness techniques; the psychotherapist and the patient “indwell” together in this experience at a multilevel dimension (physical, emotional, energetic, mental and spiritual) to allow the psychotherapeutic process to happen.

The present study was carried out to describe the psychotherapist and the patient lived experience of the Transe. The aim was to describe how this process actually works to the therapeutic effect and could relate to self-development.

The study, involving 7 psychotherapists and 13 patients, for a total of 121 clinical sessions, comes within the field of qualitative research, using a heuristic methodology, to provide a conceptual and structural description of BTE practice based on its clinical application. The heuristic method described by Moustakas, has been adapted for this particular clinical setting.

As it is described by the patients and the psychotherapists, the Transe, allows integration of the five levels, physical, emotional, mental, energetic and spiritual, to occur. At the same time a process of dis-identification from the mental and emotional contents might happen. Patients reported that the therapeutic process during the Transe would lead to a subjective state of well being, improving awareness about inner mechanisms, both on the mental and the emotional levels. The patients reported also an improved ability of self listening and also listening to others’ emotion, leading to more satisfying relationships.

The Transe as a non ordinary state of consciousness will be discussed comparing it with other mindfulness practices applied in different therapeutic contexts, both for psychological support and for medical problems. Moreover,



I will consider the Transe from the evidences coming from neuroscience studies about the effect of mindfulness practices on brain structure and functions.

Results will also be discussed from BTE theoretical framework, contrasting BTE structural boundaries with other psychotherapy approaches, mainly Bioenergetic and Gestalt.

A discussion about the heuristic method used, as a valid tool to study non ordinary state of consciousness in transpersonal psychotherapy research, will be also provided.

## PROLOGUE

*Close your eyes, relax, find a comfortable position. Slowly move your attention to your body, feel the heaviness of your body and leave it down, let all the heavy things to go down to mother earth, she will accept everything, hold everything, transform everything; you just have to leave everything to her...*

*At the same time keep breathing, follow your breath, as the air comes from up above, from the sky, filling your body with lightness; inhale and exhale, and when you exhale the light breath will go up connecting you with the sky...*

*Keep your attention to this incessant flow: everything which weights goes down, everything which is light goes up, and you stay there observing with a focused attention, like a fire lighting up in the dark...*

The very first time I did this practice it was just relaxing. Practicing it more often, I started to detach from whatever was around me, the noisy street outside, footsteps in the other room; I could detach also from what was inside: worries about some difficult situation at home, fear of not succeeding. Once I was in such a state of detachment, I could start to feel a pain, heaviness in my heart, and I could talk to my heart, ask him what was hurting him.

However, it was not always, pain.

*Being at 0, 0, like the Tao, cannot be defined; it is only possible to say what it is not, or what it is like.*

*Can be like a falling drop and I observe it in the exact moment it detaches, slowly... closing the circle, detach from the surface and free itself, free to fall, and I keep my attention to the exact moment of that beginning...*

*Once I am there I forget the drop, and the fall, I will stay there, empty and calm... and light and joy will come, but in a way that they have no name, no need to be told, I just feel them, filling me from the inside...I will become that light and that joy.*

Once I am there I can acknowledge my spiritual part, recognize that all my life

story is not so important, and whatever was bothering me is not really filling me from the outside with pain and worries, as long as I remember that I can be also light and joy.

And when I will be back to my ordinary state of consciousness, I do not need to explain, I will just know that now something is different.

When I started to use these techniques in my clinical practices, may be even when I was learning them, I started to wonder how would they relate to the therapeutic process. What was exactly happening in these non-ordinary states of consciousness?

These questions are the beginning of this present research journey.

This journey has been a heuristic process, therefore to speak about it I have to speak about myself; I have to tell how I arrived to this point and what has meant this journey to me.

## **CHAPTER 1 - My research journey**

In this chapter I will describe my research journey. This is relevant to the present study because this research project is strictly related to my journey as a researcher. The narration will start from the Ph.D. in psychiatry, when I applied brain imaging techniques to study major psychiatric diseases, arriving to a qualitative approach to explore non-ordinary state of consciousness in psychotherapeutic setting. This description will provide a framework to understand how I developed the whole research project of the present study and it will make clear why I chose a heuristic approach for it.

### **1.1 Professional development as researcher**

I will describe my research journey as part of my personal development, as they are strictly connected.

Research is a process through which explanation for natural phenomena is obtained. In this field empirical methods are used, based on observation, measurements, comparison and so on.

Research can also be a process through which meaning of phenomena is described. This kind of research attains more to the philosophical domain.

In any case research is a process of knowledge. At the beginning of every research process there is a question, rising out of curiosity, as marvel and restlessness facing the world and our being in the world.

The first question I ever had been was about me and my nature. This happened when I was 10 years old and I met a 30 years old lady with mental handicap. I heard people saying that she was like a 10 years old woman. I would stare at her astonished, because I was ten years old, and I was not like her, she was behaving like a child younger than ten. So I wondered what it was that would make her the way she was, and me the way I was, so different from her. She couldn't speak normally, I could; she couldn't move normally, I could. Even the way she would smile at me wasn't exactly the way other kids would smile at me. Why? What it was that would make the difference?

I remember that I was really shocked. What scared me was the unknown, the inexplicable; everything I could not frame in my infantile mind used to scare me. Growing up this attitude changed from worries to intellectual curiosity, so at high school what interested me the most were philosophy and science, as they seemed able to give answers.

When I had to decide what to study at university I was sure that I wanted to study the mind and how it relates to the brain. Psychiatry was my main interest. This is the reason why I went to medical school.

It was really exciting for me during the six years of medical school all the discoveries about the brain: how it works, how it can be studied to understand the bridge from the brain to the mind.

At my third year I attended a conference by Sir John Eccles, a neurophysiologist on mind-body relationship. I read also a book he wrote with Carl Popper (1981) on this topic discussing the interactionism theory of body/mind. I had already studied neuroanatomy and neurophysiology, which fascinated me as I learned how the complex organization of the brain and its electrical activity is responsible of our conscious life. Reading Eccles I had a philosophical frame explaining how not only thoughts but even emotions and feelings are generated by the electrical activity of the brain (Eccles 1983).

When I studied psychology I understood that it was good to explore the mind and explain how it manifests itself in human behavior. When I took my internship in the pharmacological lab using animal models I learned a lot about molecules as transducers of the electrical signal in the brain.

Then, I finally arrived to psychiatry. Since the beginning of his development psychiatry advocated the organic etiology as explanations of the symptoms.

I studied Bleuler, who based his nosological psychiatric classification on clinical observation and would use the microscope to describe neuronal abnormalities in the brain of psychiatric clients (Bleuler 1985). I read Jasper. In the preface of his “General Psychopathology” (1982) he said that the psychiatrist in his/her practice has to deal with individual cases, but the scientific approach to psychiatry makes it necessary to speak about general principles.

I studied Schneider (1983), who said that must be considered pathological those psychic disturbances having an organic etiology. For Schneider psychiatry has to base the concept of disease on pathological abnormalities of the “soma”.

Reading all these authors I became interested to do research to study such organic abnormalities. I started to be involved in research studies using electroencephalography (EEG) to map brain electrical activity during mental tasks, both in normal subjects and psychotic clients (Gambini 1990).

I must admit that the clients’ sufferance was not my concern; I tried to escape all the clinical practice I could, as my interest was more on basic and theoretical science.

At this stage I considered research as a scientific procedure based on empirical evidences, validity criteria and replicable results. I was inspired by Ramon y Cajal’s words: “the major sources of knowledge include observation, experiment, and reasoning by induction and deduction” (Ramon y Cajal 1999, pg. 1)

I thought I had what he called the “indispensable qualities for the researcher worker: independent judgment, intellectual curiosity, perseverance, burning desire for reputation” (Ramon y Cajal 1999, pg. 29).

After graduation I continued doing research and attained a PhD in brain imaging techniques applied to psychiatry at the University California in San Francisco. Here I learned how to use a new technique to measure in vivo brain metabolite, without cutting the brain, like I did for my medical doctorate thesis (Scarone S.1990). I could demonstrate that in schizophrenic clients there was some imbalance in neurotransmitters in specific areas of the brain (Calabrese G. 1992, Deicken 1995). I thought that research would come before clinical practice, as it was demonstrated by the incredible development of western medicine in the last two century.

Following the empiricism and rationalism thoughts, through the incredible development of chemistry, biology and physical science (Wulff 1995) it has been possible to cure many of the mortal diseases, it has been possible to scan the body searching for cancer.

Brain imaging techniques would tell us how the mind functions and I thought that research using brain imaging and in-vivo brain metabolite measurement, would

explain also psychiatric symptoms and psychological distress, from this the right medication could be produced and the disease cured.

However, when I started my clinical practice, I had to discover that this was not quite right.

During my internship as a psychiatrist I was learning how to use medications to sedate clients, to take away their delusions and hallucinations. I was taught to classify their symptoms according to DSM-III R.

However, with my surprise I noticed that I was much more intrigued by the stories the clients were captured in. The voices and images, though awful, they were experiencing, fascinated me. Where these voices were coming from? Was it just a matter of dopaminergic neurons? It seemed to me that the clients were living in another dimension, to consider them just as sick people was very reductive, even more it would enhance further their splitting between their reality, which was wrong, and ours, the supposed right one. I had the feeling that something was wrong in the way clients were treated, and one day I had the evidence of this.

A 19 years old client, was going back home after being in the hospital for 3 months, as he put himself on fire believing he was devil; while he was stepping out of the office, he turned back, glanced at me and said: “By the way, doc, I am feeling all right now, but when I’ll be back home, and the devil will come to me again, I will light the fire, again.” He smiled and walked away.

He was living in both worlds: drugs were keeping him in our dimension but for him his delusional world was as real as ours.

It seemed to me that I have gone back to the old handicapped lady. Now that I was dealing with people, their sufferance, their life, either real or delusional, different questions would come to my mind. I found out that I did not know how to answer to those questions. Even worse, I always thought that these were silly questions. Going back to Ramon y Cajal’s words: “exploring one’s own mind or soul to discover universal law and solutions to the great secrets of life... can only generate feeling of sorrow and compassion”. (Ramon y Cajal 1999, pg. 1)

I felt frustrated by the distance between my excitement about what I thought I was discovering in my research practice and the disappointment of not been able to really understand the patients and help them.

So I left everything behind. No more research or psychiatry. I started to work as a neuroradiologist. Taking picture of the brain with magnetic resonance would have been much easier: just writing on a report what was wrong about the brain, without even having to speak to the clients, not questioning anymore about thoughts, emotions, and feelings.

As I had to discover, however, I was detached even from my own emotions and thoughts. After few years two episodes happened that shocked me deeply: the death of a close friend, a clinical psychologist killed by one of his client, and a brain disease I had to deal with.

**It started as a severe headache, so that I took a magnetic resonance examination and diagnosed myself a cerebral vein thrombosis. For this I was admitted into the same hospital where I was practicing as neuro-imaging researcher. I recovered quite soon, but still I had the time to be “on the other side”. It was quite shocking to look at my fellow patients on the neurology ward, most of which could not move or speak anymore.**

**This event made me realize that a disease is not just a topic of my research activity, behind a disease there is a human being. Of course I should have known this already, but this experience made me change the perspective to consider my research and my medical practice from a reflective position.**

Even more, these two episodes made me realize that being physically and intellectually healthy was a gift. I had to use this gift in service of the others, either patients as a psychotherapists, or alumni as a teacher, or even as a mother for a child (I adopted my husband’s little boy whose mother died when he was four years old).

To justify life as a gift I had to consider a spiritual dimension of life, something beyond its material appearance.

From this new perspective I realized that there was something missing in the way I was looking at life in general and my research and clinical practice in particular. Science might have been able to answer intellectual questions about the world, the real world we can experience with our senses and measure with all sort of tools. However, science was not able to give a higher sense to the existence. What was the usefulness to know everything about a disease if that would not be used to heal



human beings suffering because of that disease? It was not enough to take away the symptoms from the body, as long as the soul was aching.

Now I was ready to accept a different kind of questions. In that period I was reading a book by F. Capra (2005) about the integration of the scientific world of physics with eastern philosophy. I could see that reality can be acknowledged by both a scientific point of view and a mystical perspective; these two do not exclude one another.

So I decided to go back to my main interest: the mind.

## **1.2 The meeting of transpersonal psychology and Biotransenergetica**

However I did not think of going back to research, I went back to clinical practice in psychiatry, but from a different approach, so I chose a transpersonal psychotherapy school.

Historically transpersonal psychology is considered the fourth force.

Psychodynamics, the first force, considers symptoms as the resulting conflicts between inner urges and social constraints; in the therapeutic process it gives importance to introspection (Mac Williams 2003). Behaviorism, the second force, started from experimental observation of operant conditioning, and reinforcement principles. Behaviorism further included cognitive theories on memory, learning and neuroscience evidences of brain functioning (Craighead 2003). Humanistic, the third force, considers the individual in a continuous process of evolution, through the development of will, creativity and all the positive aspects of human nature (Maslow 1971). Humanistic psychology gave rise to terms such as client-centered therapy, peak experiences, self-actualization, and group therapy.

Transpersonal psychology, going even further, includes self-transcendence in the personal developmental process and emphasizes the centrality of consciousness (Walsh 1980).

The birth of transpersonal psychology is traced ideally to Jung, who considered the psychological aspect of spiritual experiences, and to Assagioli, creator of psychosynthesis, who was the first to use the term transpersonal. As pointed out by

Assagioli (1973) this term, first introduced by Maslow, is more suited from a scientific point of view to indicate what is beyond or above ordinary personality. According to Assagioli's psychotherapeutic approach, the individual is in a constant process of evolutionary growth, and the development of individual potentiality occurs mainly through will and creative and positive elements of human nature (Maslow 1971).

Within this vision we can recognize an analogy with humanistic psychology, which sees the process of individual development through the eyes of the theories of humanism and existentialism, according to which human beings freely choose their path in order to develop their potentialities even outside prearranged schemes and values.

Transpersonal psychotherapy goes even further considering not only the personality of individual and their development, but also consciousness itself, interpreted as the most intimate experience of one's own self, as a part of a cosmic and universal whole; a self connected with the universe rather than a self that identifies with the contents of the mind. We are not talking about a *conscious I* or about the *unconscious*, but rather about states of consciousness through which individuals make contact with aspects that transcend reality as we usually experiment it. The spiritual aspect is of special importance for transpersonal psychology; an aspect already explored by Jung, by W. James before him and even by Neumann (Walsh 1993).

The transpersonal deals with a dimension beyond the boundaries of our conscious experience, it's a psychological approach to transcendental and spiritual experiences.

With humanistic psychology as a starting point, transpersonal psychology then embraces oriental philosophies such as yoga and Zen, it inserts practices such as martial arts, and it includes the holotropic breathing described by Grof (1985). The approach to the person is a holistic one, meaning that the various levels such as physical, energetic, emotional, mental and spiritual are considered as an interconnected whole.

Therefore I decided to approach psychic disturbances from a different perspective: not as a psychiatrist but as a transpersonal psychotherapist. This is how I met Biotransenergetica.

### **1.3 The history of Biotransenergetica**

In Milan, the city where I live there is a psychotherapy school with a transpersonal approach. The school is directed by doctor Lattuada. He is a medical doctor specialized in clinical psychology, which developed the method called Biotransenergetica (BTE) with his wife, a Brazilian psychologist, in the 1980s. In order to fully understand BTE, it's very important to briefly describe the socio-cultural context in which Doctor Lattuada was formed, as the environment was crucial for the development of this approach.

Doctor Lattuada, who graduated in medicine in the 1970s, integrated his academic medical knowledge with the study of Chinese medicine and homeopathy, and he used shiatsu techniques as well as homeopathic drugs in clinical practice, as a general practitioner.

Then he specialized in clinical psychology, when the Italian psychology field was shaken by the theorization and controversies of the anti-psychiatric movement, which led to the enactment of the Basaglia law in 1978 to reform the institution of psychiatric hospitals. This movement historically took position against the medical concept of psychic discomfort, considering that it often presents markedly social connotations. In the 60s and 70s of the last century there was also a strong opposition to the use of practices such as electroshock, employed more as a repressive tool rather than a therapeutic technique, and to the indiscriminate use of newly discovered anti-psychotic drugs. The opponents believed that these practices didn't leave much space for interventions of psychological and rehabilitation support, which aim is the re-integration of the client in the family and social context of origin. As Basaglia (1997) said psychiatric hospital would become a sterile place, clean and tidy, well functioning, where the client's disease would be

just a “trouble” not only for the client but also for the family and the society; a “trouble” to be cancelled by every means: electro-shock or medicines.

Lattuada studied and examined in depth the theories of Maslow’s humanistic psychology.

Humanistic psychology described the human dimension in its evolution from the fulfillment of merely biological needs, to personal self-fulfillment. As Maslow described in the hierarchy of needs, human development goes from the most fundamental levels to self-actualization. This evolution does not consider only needs and impulses but also values. It contemplates not only the realization of personality beyond individual conflicts, but also the process of self-realization (Maslow 1971). This process occurs through qualities such as creativity, which is expression of the freedom available to mankind in order to intervene on its destiny. The concept of choice in opposition with mechanistic and reductionist vision of mankind is central.

According to A. Maslow, mankind, during its existence, must fulfill the task of realizing the sense of its own individuality. Maslow distinguishes needs, which derive from a state of deprivation, from meta-needs, which represent the boost towards growth and evolution. Starting from physiological needs we move upwards to needs of security, belonging, esteem, till we reach the self-realization need. The most elevated level is the need of transcendence, considered as the tendency of going beyond one’s self, feeling as a part of a wider reality, a cosmic or divine reality (Maslow 1971).

According to humanistic psychology the study of psychology must be based on the experience that involves the person and on the meaning it has for the person, what counts is the experienced rather than observable behavior and explanations; it’s a holistic approach to the person.

Then Lattuada deepened his psychological education with the study of Lowen’s bioenergetics.

Based on Reich’s theories (1969), which affirm that a vital energy controls both physical and mental state and their mutual interaction, Lowen (2009) elaborated Bioenergetics. On an essentially physical level, vital energy depends mainly on breathing and a lot of Bioenergetic’s practices aim to improve this function. For

what concerns psychodynamics, Lowen, who came from a psychoanalytical background, re-elaborated psychoanalytical theories integrating them with a physical-corporal perspective. Bioenergetics focuses many interventions on corporal movements, which by improving posture and muscular tone obtain results also on a psychic level.

These premises allow a better understanding of Doctor Lattuada's vision of human beings and medicine. In particular, although Lattuada is a doctor himself, he senses "a sort of complicity between doctors and clients such that tacitly it is agreed that health is absence of illness, and that curing, and respectively healing, mean to be rid of, or to not feel the symptom anymore" (Lattuada 1998, pg. 15). Therefore, he develops a vision in which individuals become authors, in first person, of their own well-being, both on the physical and the psychic level. According to this vision, it becomes essential to know how to recognize and value the infinite qualities that each being possesses in order to evolve both physically and psychologically – as described in Maslow's evolutionary pyramid – and also spiritually. Hence, the symptom becomes an ally that indicates which way to go. We are not talking about cure, but rather about healing, as a process of personal evolution, and precisely because of the implication of the spiritual level, trans-personal.

A trip to Brazil, country of origin of Lattuada's wife, also a psychologist, represented a particularly significant occurrence in his life.

During this trip Lattuada made contact with the practices of Brazilian shamanism, partly connected to the afro-Brazilian culture of Umbanda and Candomble.

By fully experiencing the rituals he understood that, similarly to other forms of shamanism, even for Umbanda "the knowledge of existence of what is outside occurs through the experience of interior deepness, and self-knowledge through the profound immersion in the nature to which we belong" (Lattuada 2005, pg. 19). The experience of shamanic rituals gave birth to the interest in non-ordinary states of consciousness; particularly by observing how the "curandeiro" (healer), in a state of trance, contacts spiritual forces and performs the healing.

To describe this state of consciousness Lattuada uses the Portuguese word *Transe*, which is defined as that state allowing the individual to be in contact with the

divine dimension (Lattuada 2005). As the concept expressed by this word is quite complex and peculiar of BTE epistemological bases I prefer to use this spelling. During the 80s Lattuada organized theoretically the BTE model of psychotherapy and founded a school that was approved by the ministry of education and research at master level of psychotherapy for both psychologists and medical doctors. This is the school where I studied transpersonal psychotherapy, but it has not been just a theoretical study it has been a journey into consciousness and spirituality.

#### **1.4 My journey into consciousness and spirituality**

In the next section I will summarize BTE psychodynamic and psychotherapy, here I will describe how the training program changed myself and really changed my clinical practice, paving the way to my future research development.

The training included formal classes on clinical psychology and different psychotherapy approaches, and experiential workshops to learn different methodology to reach non-ordinary levels of consciousness, like meditation and holotropic breathing following Stan Grof's model (Grof S. 1985).

Until then I followed the academic and medical notion of consciousness that considers just two normal levels: waking or sleep; all the others would be considered as pathological (Vaitl D. 2005).

Here I started to experience different levels of consciousness that can be used to explore transcendental aspects even in a therapeutic setting.

The experiential workshops had been very formative for me for two reasons.

During the workshops we used to seat in circle on the floor, dressed in white comfortable clothes. At the beginning this has been very unusual and challenging for me as I was used to group meeting in classrooms with PowerPoint presentations, where people were listening to me ready to argue about what I was saying, critically over viewing my position; whereas here the people in circle were listening to each other with empathy and with open hearth. Back then at the end of the group meetings I would feel excited for my success or depressed and ashamed for a failure; now I would feel like a sense of joy for having been part of a journey

where each one of us made new discoveries about ourselves, about the others and the world around us. I had to switch my mind attitude from the ego to the self. Moreover during the workshops I learned to manage non-ordinary state of consciousness. The aim was to allow a process of ego development to reach a stable and coherent level of awareness going further on my way to develop the inner self in its whole spiritual potential.

There are many methods to induce a non-ordinary state of consciousness. During the training in BTE I learned to use guided imagery, breath work, mindfulness practices and meditation associated with body work (see next session for a detail description of the different practices). Sometimes, drums or other music were played to intensify sensorial experience.

From BTE theoretical perspective, working in these states is supposed to allow the person to identify the blockage to the energy flow, responsible for the symptoms. To be in a non-ordinary state of consciousness is also a way to access to archetypal forms, create the possibility of profound experiences of connectedness and mystical experiences. These processes have been shown to determine significant trait changes, they may be seen as useful not only for personal growth but for therapeutic purposes as well. For BTE is important to reach this spiritual level where there is no disease.

I tried some physical practices, during which the body movement was accompanied by the drums. So I learned to listen to the drum beat and feel his power and recognize my own heart's beat (which to me used to be only felt as annoying extra systoles) as my inner source of energy.

As I will explain in the next session BTE gives special attention also to the energy coming from natural elements. This aspect has been really challenging for me, as I always thought that rationality should come first. However, it has been also really revealing.

Working with the archetype of the plants, in the wood, leaving on the side all my mental restrains, allowed me to approach in a different way some difficult issues related to the mourning for my father's death and my difficult marriage. For me the contact with a transpersonal dimension would find the expression through a poetic

act or artistic expression using the camera. At page 17 I report how I overcome those difficult life events using the archetype of the wood as a metaphor.

To me it was really a new and transformative experience to deal with these practices.

However, these practices were not just for a personal developmental process, it was more like a way to learn healing techniques which I had to try on myself first, to apply then on clients.

In these four years I did learn many things from an intellectual point of view, but what is even more important I had a chance to get really in touch with my emotions and feelings. I could explore my spiritual dimension. Working on me opened my sensitivity towards the others.

Another important change has been my reflections on spirituality.

In these years I have become convinced about the existence of a spiritual dimension, not from a religious point of view, but a humanistic perspective. Even more I could see how this dimension could have a therapeutic role.



***The wisdom of the wood.***

*He humbly gives  
flowers and fruits  
and nothing asks.  
With his roots,  
in the soil or between the stones,  
he goes deeply  
looking for nourishment.  
He turns his glance upwards,  
asking the sun  
for the light.  
He does not ask the air,  
that fondles him,  
to stop.  
He accepts the rain,  
as well as the fire,  
because this  
is his life.  
The wood when time comes  
let it go:  
he dies  
to be born again.*



During my training I took two travels in countries very different from Italy, or even Europe, which were like an opening experience to a world of spirituality. In 2008 I went to India for a meeting on psychology and spirituality, organized by the Association of Transpersonal Psychology, held in New Delhi. It was really interesting to see that it is possible to speak about spirituality in the psychology field, to meet people from many different cultural and religious backgrounds sharing opinion about the subtle line where psychology and spirituality meet each other. It was even more interesting the spiritual dimension I could see on the streets.

In India I felt overwhelmed by physical perception: the noise of chaotic traffic and people, bright colors and strong smells. All the aspects which with my western eyes I would judge as misery were extremely physical. However Indian people would live with absolute naturalness in the dirt, in the noise and in promiscuity with animals, as if this was not the true reality; even if absolutely present in this world they would have the sight somewhere else. The girl carrying with elegance a plate of dung on her head, an old man proudly seated on a huge load of sugar-cane pulled by a skinny oxen, young smiling boys pulling a bicycle carrying an heavy weight in the midst of the city traffic, they all were not showing the physical effort or discomfort of their job, my impression was that this was because their inner attention was toward some other dimension, their attention to the spiritual world would not drag them down in the suffering and disgust. Such a difference from the faces and gesture of people in Italy going to work seated in a comfortable train, hiding behind a newspaper, isolating themselves in a headphones not to hear the noise from other people! In our comfortable life we feel the physical heaviness of our existence much more than the Indian people who live in heavier physical condition than us. It is even more absurd from this point of view how we struggle with all sort of yoga and meditation classes to forget about our body and its heaviness.

In 2010 I went to Brazil, to study on the field the background of Umbanda described by my teacher, Lattuada (2005). It was really interesting to see how people in Brazil live within this spiritual dimension. Again I could see how spirituality can have a healing power in a psychological dimension. I saw a “mae do

santo”, a woman which is considered like a shaman, practicing like what in the western world would be called a counselor.

These two experiences brought me in contact not only with other cultures but mainly with a different approach to spirituality. Their spirituality was more alive than all the mental reasoning I was used in my own world.

Eastern medicine and philosophy, like all other forms of shamanism, have a spiritual approach to the human being. In fact they consider all the physical and psychological aspects as expression of a wider spiritual dimension. Moreover human beings are in profound communion with the natural field they live in, so that the spiritual level of the elements, air, water, earth and fire, has a strong influence on them. Humans and nature are deeply connected and in equilibrium. For this reason they use a lot natural elements for healing purposes, and the healer is a medium through which the natural power of the elements acts.

However, as I was raised and educated in a western culture, I started to feel the need to frame the spiritual experiences in a more modern, and even post-modern, view.

In my experience in India and in Brazil I could realize that spiritual attitude can be almost inborn, I saw how in those people every act was informed by spirituality. Spirituality seems to be something they would feel rather than think of. Moreover they do not need any particular practice to enter in a state of consciousness which would bring them into a spiritual level, for them being at such a level was as natural as breathing. This attitude is very different from what happens in the western countries, as I know that some of the people working with me in the transpersonal field would often say that they felt like a separation between the spiritual experiences and their daily life.

People going to see the *mae do santo* or the *guru* were looking for some help because of some discomfort either on the physical body or at spiritual level; the healer would listen to them and seek the answer in a spiritual dimension, a dimension which is familial to them as they believe it is real as much as the physical one. At this point my question was: how is it possible to frame the spiritual dimension in a western approach to psychotherapy.

### **1.5 The research question: a different approach to therapy and a new research approach**

As I described previously, transpersonal psychology and BTE changed my mind frame to look at my clinical practice.

I know that now working with clients is different than it was when I used to practice on the psychiatric ward. It is not just prescribing drugs and seeing what would happen. Now when the client enters the office it is like looking at a white canvas. As he talks we start to interact and the picture starts to reveal. I learned that as psychotherapists I don't have to plan in advance where to lead the client. He has to discover his own way by himself, I can be there to support him, being in connection, not just cognitively but with empathy and at a spiritual level as well, I can try to help him in his journey toward personal development and spiritual growth.

In transpersonal psychotherapy it is very important to work in the therapeutic setting with non-ordinary states of consciousness. These may be defined as those states in which there is a change in thinking, feeling and perception in relation to the ordinary baseline consciousness. In BTE both the psychotherapists and the client can be in a non-ordinary state of consciousness, sharing the same field, which is called *Transe*.

As I already said at page 14 the word *Transe* (spelled in Portuguese) describes this state of consciousness first observed by Lattuada in the Brazilian shamanic tradition. However, Lattuada extended the concept of *Transe* to describe, from a psychological perspective, the state of being integrating the five levels of experience (Lattuada 2012). From a neurophysiologic perspective *Transe* can be described as a state of consciousness, that is the self-awareness of the lived experience. According to Lattuada, *Transe* describes the state of consciousness as a modality by which we recognize our state of being in the world, both from a physical and a relational perspective (Lattuada 2004), therefore, from a systemic point of view, *Transe* can be seen as a field in which we are immersed interacting with other people. In this sense *Transe* is the field of non-ordinary state of consciousness shared by the psychotherapist and the client.

But what exactly happens in this field? From this new approach to psychotherapy new questions raised in my mind, paving the way for my research journey.

From the experiences in India and Brazil I realized that spirituality can be brought in the therapeutic setting, however my concern was how I could do it, being aware that I am not acting like a priest or a shaman, as I am not either one.

Even if I might agree with the holistic vision of human being as expression of physical, psychological and spiritual aspects, many times I would feel an underneath discrepancy so that the spiritual aspects are considered as folklore or even out of place in some context such as a clinic.

When I attended at the Eurotas (European Transpersonal Association) conferences I met a lot of people who would think and behave as they were in contact with a spiritual dimension but I had some concerns about the therapeutic aspects, strictly speaking, of their spiritual practices.

Considering all these aspects, I started to ask myself how the “mechanism of action” cited in BTE, actually works to therapeutic effect and can relate to self-development. How would the non-ordinary states of consciousness relate to a therapeutic effect? From literature searching I knew that mindfulness was used in other psychotherapy approaches, but here it was different as it was not just a tool, it was something involving the psychotherapists together with the client. This question has been forming through all the period of my training at the transpersonal psychotherapy school. In fact, I knew what it was like to be in a non-ordinary state of consciousness, as I experienced it both from the client’s and the psychotherapists’ side. But knowing it was not enough. How could I describe it to somebody that did not practice it? How to explain how this worked in therapy?

When I went to a meeting on evidence based psychotherapy, I could see that clinical trials and group studies could be applied to psychotherapy as well. I realized that what I needed was to look for a scientific approach to the psychotherapy model I was practicing.

Speaking about science: what is scientific? If it was easy to answer to this question in the medical field it seemed to me very hard to find the right answer in the psychotherapy field.

The quantitative research methods I used for the biochemical approach to psychiatry would not be useful in the field of psychotherapy. Brain metabolites were somehow measurable, I could count them, compare their levels between groups, correlate their concentration in the nervous system with symptoms. I could use scales to measure symptoms. Now I was interested to do research about something that could not be counted, I was interested to understand the process by which something happens.

In one word I had a background in quantitative research and it was difficult for me to understand from this perspective how research could be conducted on something which was not so simple to measure, or at least was not measurable objectively. I had to change my mind toward a different approach; this is the point at which I heard about qualitative research.

If quantitative research has to do with measurements and correlations, qualitative research has to do with description and interpretation, quantitative methods are useful to test hypothesis whereas qualitative methods are tools for understanding the meaning of a process (Cresswell 2007). What has been even stranger to me is to discover that in the field of qualitative research the researcher's position cannot be disregarded. I went back to what I read from Heisenberg (2008), about the influences of the observer on the object of observation. If it's true for quantum physics, it's even obvious for psychotherapy: if I want to describe how psychotherapy is effective and understand how it works, I have to be aware in my practice of the way I work, what I do and the effect of my actions in the field where I practice. I also have to consider how the practice of therapy and the ongoing research would change my own mind and perspective.

At the beginning of this journey what questioned me the most was the issue how can a psychotherapists be scientific and emphatic at the same time? As I had very bad experiences of physicians pretending they were practicing science and acted very badly with clients. When I used to work as a psychiatrist there was a separation between research and clinical practice. Even if my research projects did not deal with basic sciences, still I was not much involved in the therapeutic process. Now it is different as my clinical practice is the object of research.

What I discovered since the beginning of this research journey is that in both therapy and research I have to consider my thoughts and feeling as part of the process. Now I am in a different position as my research activity is strictly bounded with my therapeutic activity and vice versa.

From this reflective position I could focus the outcomes of this study. Through this study I would like to promote BTE among health care professionals, both in the medical and in the psychology field.

This need is evident considering that students from the BTE School have sometimes hard times to find an institution that would accept them as residents, because of some prejudice toward transpersonal and ignorance of BTE. To be effective in this, however, it's important to give a theoretical framework of BTE, based on a clinical study.

The other reason to undertake this research journey was to develop a method to promote research practice among Eurotas community. Eurotas is a cultural association with many professional members. For almost five years I have been involved inside the association as a delegate member, and I have been working as chief editor of the Integral Transpersonal Journal, the official Eurotas Journal.

From these two experiences I could see how they have a preconceived idea toward research. They feel ostracized by the mainstream psychology field, and at the same time, they are struggling to get accreditation by the academia and health institutions. Now that I could see how research can help clinical practice and how this can be applied to transpersonal, I would like to share my enthusiasm with other practitioners in the Eurotas community.

This was the starting point to create a research division inside Eurotas with other colleagues. We called it Eurotas Division of Transpersonal Research.

We shared a same feeling of the need to initiate research programs among the Eurotas community, as a starting point to promote transpersonal psychology in the educational field and to diffuse transpersonal psychotherapy in mainstream psychotherapy. Each one of us has a particular field of expertise; mine will be related to the application of qualitative research in transpersonal psychotherapy, as I did for this study.

**Concluding summary**

This has been my professional development both as a clinical practitioner and as a researcher. This is how I found myself on this research journey, trying to define BTE clinical application using a qualitative research approach.



## CHAPTER 2 – Biotransenergetica

In this chapter I will describe the Biotransenergetica model of psychotherapy. I already talked about its history; here I will describe the theoretical framework from the psychodynamic and psychotherapy point of view.

I will also provide some epistemological background and some scientific references to the model itself.

This description is important to help the readers to enter into the data collected for this study and to better understand the BTE transpersonal psychotherapy approach

### 2.1 Biotransenergetica - Psychodynamics

As I illustrated in the previous section, BTE theoretical framework has been organized in many years, from the integration of humanistic psychology, especially Bioenergetics, based also on Lattuada's clinical experience, in more than twenty thousand hours of clinical session.

Here I will describe BTE's theory, and how it is clinically applied.

The name Biotransenergetica explains the holistic approach to the individual: *bio-* concerns physical aspects, *Transe-* concerns spiritual and transcendental aspects, and *energetica* refers to a transcendental dimension expressing itself as energy in the physical dimension. With a holistic approach to individuals, BTE merges the physical and corporal aspects of Lowen's Bioenergetic model (Lowen 2009) with transcendental aspects.

Based on Reich's model (1973) of an energetic aspect informing the body and influencing the psychological dimension, Lowen developed the Bioenergetic model, in which the energetic aspects were inherent the body, in relation with the breath. BTE goes further to consider also the spiritual dimension of the human being.

From an ontological perspective, self is considered as a part a transcendent being. In this regard BTE can be traced in the broadest field of transpersonal psychotherapy.

Maintaining the concept deriving from quantum physics, which states that matter and energy are the expression of the same principle, BTE considers the individual, in his physical-mental-emotional-energetic and spiritual unity, which can be described on a psychological level as a single event animated by vital force, having the quality of polarity and rhythm. Lattuada names this principle *original dynamic*, which expresses itself as an interconnected trinity (matter-energy-spirit), made of two polarities and their relation (Lattuada 2004).

If the *original dynamic* takes place with harmony and the energy is free to flow, there will be balance between the different parts; the qualities of luminosity, fluidity, brilliance, vivacity, harmony, freedom, respect, synergy, sharing, pulsation and resonance will emanate from the subject. So, we can say that it manifests as “*isomorphism of well-being*”, and the subject is in a state of “*harmonic Transe*” (Lattuada 2004). The term Transe, already explained at pages 14 and 21, is a term indicating the level of conscious experience. Being in harmonic Transe means that all levels, physical, emotional, energetic, mental and spiritual, are integrated into a wholeness and what is experienced at one level resonate harmonically at the others.

On the other hand, if there are blocks in the flow of energy, interruptions, we will observe in the subject features of asymmetry, low mobility, contraction, a sense of heaviness and oppression, of opacity. In a situation of block, the individual will find himself struggling in a dualism.

If the block persists, it becomes chronic, initially regarding the individual only on a physical or emotional level, but if not recognized and resolved in time it can affect the person in an increasingly profound way, involving the energetic and mental levels as well. We can say that the subject is in a *chronic Transe* (Lattuada 2008).

The lived experience of a dualism, i.e. love/hate, or success/failure (see the table in Appendix 1, pg. 159), can express itself as physical symptoms, stomach-ache or low back pain, in line with Lowen’s Bioenergetic model

(Lowen 2009). It can also result, on the energetic level, in behaviors such as arrogance, which can hide fear of failure or can be expressed in burst of anger. It can manifest itself emotionally as sadness or even as the complex symptoms of a major depression episode. It can also be a mental construct that leads to stereotype behavior (Lattuada 2008).

In the table in appendix 1 it is possible to read the map of the dualisms in relation to the system of the energetic levels.

When the individual is in a situation of chronic Transe, struggling in a dualism, in order to get out he/she must transcend the dualism itself, and understand that it's not *"this/ or that"* but *"this and that"*. In order to do so, it's essential to help the subject to find the necessary energy to take this step, and help him to find the right direction.

The origin of these blocks can be recognized in traumatic events, either remote or recent. Once the block has being recognized the client stays in contact with it, experiences either the pain, or the anger or whatever it is, physically, emotionally or mentally. The client can even try to overcome his/her personal biographical history and experience the archetypal plane. All the energy then has to be mobilized with a catharsis on a physical and emotional level, or with an insight on a mental level; then transformation can happen, so that the lighter of the two qualities can express itself freeing the subject from the symptoms. At the end of the process the symptom, the problem, rather than being re-solved is dis-solved (Lattuada 2004).

These theories and methodologies may look similar to other psychotherapy models, like Bioenergetic and Gestalt, but the peculiarity of BTE is the reference to a spiritual level (Lattuada 2012).

According to BTE, the growth of the individual doesn't only concern the cognitive and psychic level, but it extends to include a trans-personal level.

Furthermore, unlike other theories of development, BTE unifies the cognitive and psychic level with the physical-energetic body.

The unification is described using two different maps: the chakra and the tension bands described by Reich.

The concept of chakra as energetic centers has a long cultural tradition based both on philosophical and spiritual grounds and on empirical observation in the oriental traditional medicine, from India and China (Irwing 2005). Within this context, the chakras are considered as energetic centers in relation with some structures of the Central Nervous System (CNS) and of the endocrine and immunological system (Mc Carty 2007).

A correlation between the autonomic and CNS has been suggested by some authors using EEG techniques (Chang C.H. 2001, Chang C.H. 2013). The relation between the endocrine and the Central Nervous System (CNS) is based on the endocrine complex going through the hypothalamus-pituitary-adrenal axis. The endocrine, immune and nervous systems are in relation through a wide range of peptides working as neuro-modulators, suggesting that through the neuro-endocrine system, interactions between mind and body might take place (Elenkof 2005).

Moreover, the immune system, mediates the response from- and towards- the external environment. According to the model of psychosomatic medicine, environmental events and/or intra-psychic conflicts arouse mental states that alter the physiology and finally provoke pathological changes in the corporal function and structure (Herbert 1993). Similarly, spontaneous or induced mental states can act on the neuro-endocrine and immune system.

The other theoretical background comes from Reich's observation of seven bands of muscular tension (Reich 1973). These bands would prevent the energy to flow, causing different symptoms. Lowen, further developed this theory developing a map to describe different psychological structures in relation to these levels of tension.

Going back to BTE, Lattuada combines the chakra and the tension bands, with the corresponding dualism, as described in the table in appendix 1. Speaking about the chakras Lattuada refers to the Indian tradition which defines seven chakras (Govinda 2002).

Here I will briefly discuss each level.

I level: it's associated to the first chakra and the pelvis tension band. On a physical level it corresponds to the adrenals and the external genitals.

Concerning behavior it is expressed as the aggressiveness necessary to protect the vital space for one's own survival. A chronic state on this level leads to live life as a constant struggle; everything coming from the outside is seen as a danger.

II level: it's associated to the second chakra and the stomach tension band. On a physical level it corresponds to the internal genital organs, the kidneys and the lower intestine. The corresponding behavior is tied to the pursuit of pleasure and to avoid pain. A chronic state on this level leads to an egoistic behavior where everything is experienced as a source of pleasure, and so to be pursued, or vice versa to run away from, if it provokes pain.

III level: it's associated to the third chakra located at the level of the solar plexus, and the diaphragm tension band. It includes the stomach, the liver, the pancreas and the upper part of the intestine; it's associated to the digestive and metabolic function. On a behavioral level it corresponds to will, to personal power in relation to others, to find one's own place in the world. A chronic state leads to excessive competitiveness in order to affirm one's own power over others, and therefore to the abuse of power.

IV level: fourth chakra, situated at the center of the chest, it includes the heart, the thymus gland and the lungs; it corresponds to the thoracic tension band. On a behavioral level, it can be related with the affective openness to life; it's harmonizing leads to an attitude of trust towards others; it leads to forgiveness of those who have hurt us, to compassion for those who we cannot love. Conversely, a chronic block on this level leads to emotional and affective closure, to resentment.

V level: fifth chakra and the dorsal tension band. It is located at the height of the neck; it's associated to the thyroid, the throat and the ears. From a behavioral point of view it represents the level of creativity; it allows the expression of one's own talents.

VI level: sixth chakra, in relation to the pituitary and the eyes and the ocular tension band. It expresses the ability to go beyond the mental and rational level; it's the observation that doesn't judge.

VII level: seventh chakra, at the top of the head, in relation to the epiphysis and the cerebral cortex; it corresponds to the eyes tension band. It's the level of intuition and transcendence.

These levels must not be interpreted as hierarchic sub-systems, but rather as the expression on different levels, each time more complex, of the vital energy itself, understood as the principle of existence. It is the task of human beings to express in one's existence the most complex level, the transpersonal or spiritual one. In order to do so, it's necessary to let the energy flow, and so it's considered worthwhile to free oneself from psychological, cultural and social blocks, that impede the flow of energy. The chronic Transe (indicated in the table in appendix 1) are nothing more than blocks of the system, which chain the individual to the lower levels.

Another peculiar aspect of the BTE model, derived from the Brazilian shamanism tradition (Lattuada 2005), is the contact with archetypal forces, represented as metaphors of natural forces (fire, metal, earth, water, air), in order to enhance the energetic aspect in relation with a specific quality of experience.

Whereas in the practice of Umbanda the shaman invokes the Orixàs (supernatural forces, according to Afro-Brazilian culture) and their qualities, in BTE the reference is only valid because they are considered "expressions of an existing entity to which mankind's psyche gives a meaning" (Lattuada 2005, pg. 26), recalling what Jung named collective archetypes.

However, while Jung considered archetypes as intra-psychoic phenomena, deriving from an elaboration process of cosmic energy, in BTE they are considered as real and authentic energy expression of a transcendental dimension. This energy might interact with the physical dimension and through non-ordinary state of consciousness is possible to experience it.

The reference to a relation with natural elements made by BTE must be considered in the light of the theories elaborated by environmental psychology, which has demonstrated how natural environments influence human being's behavior whether we consider social behavior - see the effects of green areas in the cities - or the processes of healing, both from psychoic or physic diseases

(Nenci 2003)

These theories have been re-elaborated by eco-psychology. Beyond those that can be considered new age drifts, the reasoning and studies on the positive effect of natural environments on the psyche are numerous and valid, whether we consider evolutionary theories (Balling and Falk, 1982; Kaplan, 1987) or constructivist ones (Lyons, 1983; Tuan, 1971), not to mention the theories of bio-filia, promoted by Wilson (1984) and experimentally studied in depth by Frumkin (2003).

Back to BTE, therefore, natural elements are understood as expression of energy that manifests as quality on a psychological level. Through the practices that we'll describe further on, it is possible to enter in contact with the energy and with the qualities of that specific element.

Furthermore, BTE, according to a transpersonal vision, considers the possible influences of the natural elements found in the environment on a more subtle level, on an energetic and spiritual level. For example, recalling the quality of fluidity of water, and inviting the client to feel this quality on a physical level, obviously working on an energetic and spiritual plane rather than on a mental one, results in the person embodying this quality, and being able to activate it also on a personal level.

## **2.2 Biotransenergetica - Psychotherapy**

Here I will describe how these theories apply to the therapeutic process. First of all it is useful to remind BTE assumption that the disease doesn't exist, it is a state of the person. Beyond the provocation inherent in such a statement, it means that the symptoms referred by the person tell us about his/her way of being, his/her way of relating with him/her self and the others. The symptoms shouldn't be treated as something to remove, but rather as allies that show us the psychodynamic process causing the state of suffering. Symptoms are the expression of ego identification; a higher mode of consciousness may favor the overcoming of this ego identification (Walsh & Vaughan 1980).

Therefore psychotherapy is seen, both from a theoretical and practical point of

view, in agreement with Assagioli, as a way to help individuals in their “constant process of evolutionary growth ... - in order to favor the - development of potential through the will and the positive and creative elements of human nature” (Lattuada, 2012, pg 65).

From a therapeutic point of view, BTE talks about self-healing, meaning that it’s important to call the attention to the individual’s responsibility of his/her healing process.

Similarly to other transpersonal psychotherapies, BTE pays special attention to non-ordinary states of consciousness, through which it is possible to experience transcendental realities (Kaspro & Scotton 1999).

In BTE the uniqueness of self-experience is pivotal. In the therapeutic process, inner experiences and felt sense are essential. These are contained in the concept of *Transe* (Lattuada 2012). *Transe* is a non-ordinary state of consciousness, a field, in which the psychotherapist and the client indwell together. Being together into this field they experience it on a multilevel dimension (physical, emotional, energetic, mental and spiritual) using mindfulness or psycho-corporeal techniques.

The word *captation* is used to indicate this modality of listening into this field. In this context the term, which literally refers to the reception of radio waves, is used to indicate a modality of listening and perception of the felt sense, feeling in the stomach rather than in the brain.

The concept of *captation*, similarly to the felt sense described by Gendlin (1996), represents a way to relate with the world mediated not by rationality or logic but by corporal sensations, associated with expression on an emotional level.

*Captation* can occur on the psychotherapist’s side or on the client’s side, during the various practices.

Being together, the client and the psychotherapist, in the *Transe*, the field, they explore the five levels, physical, energetic, emotional, mental and spiritual; what emerges in each level is verbalized in terms of feelings: physically (I’m hot, I feel weight), energetically (I feel the heartbeat, the movement of fluids etc.), emotionally (I’m scared, I’m sad etc.), mentally (thoughts, memories), and



at the transpersonal level (intuitions, visions). Both the psychotherapist and the client use the present tense and the first person to describe their experience, to be in the “here and now” dimension.

The psychotherapist can possibly intervene by using *magic words*. This term refers to words that, through an interior listening attitude, emerge to consciousness, guided by the felt sense rather than by observations or mental elaborations avoiding judgments.

In fact, the judging mind, critical observation and rational thinking are left outside this field; whereas, compassionate love and self-awareness observation are required to allow subtle sensations to emerge in a felt-sense.

The psychotherapist and the client indwelt into the Transe navigate it, sort of speaking, using different practices.

These practices are intended to connect the person with the transcendental dimension. Either they start with movements or touches, either they are like meditation practices, all of them, act integrating all the five levels (physical, emotional, energetic, mental and spiritual).

Here I will focus the description on those practices used to induce the field of non-ordinary state of consciousness, distinguishing the psycho-corporal from the mindfulness.

### **Psycho-corporal practices**

The activity on a physical-corporal level is always understood as expanded to the physical component of what surrounds the individual, to the outside world energies interconnected to him/her. Therefore, working on the physical level means to work with subtle energies. Similarly, working on the psychic level, with words, goes beyond the rational level of analytic, cognitive or other kinds of therapies.

The subject performs the movements, paying attention to all levels. The integration of which can also be described as an integration of Mudra-Mantra-Yantra. Lattuada refers, again, to ancient Indian culture to describe what happens at a psychic and physical level.

Mudra, in Hinduism and Buddhism is a symbolic gesture through which the

spiritual dimension interacts with the physical one (Feurstein 2003). Similarly Mantra is a sacred utterance having the power to connect with the spiritual dimension. Yantra, originally, referred to any instruments or machine, with mystical magic power, it is used here to refer to the level of vision or insight (Lattuada 2008).

There are two kinds of bodywork practices: movements that the subject performs or touches that the psychotherapist performs on the subject.

### Dreaming Body

This term indicates a complex of corporal practices that the subject performs guided by the psychotherapist. It is a sequence of movements that act on the physical level like a *mudra*, like an expression of energy acting on all the levels, as I described earlier on; this is why the structure of the movements must be followed and so, gradually, during the execution, the state of consciousness changes and contents will appear, as moods on the emotional level, as corporal sensations on the energetic level, as memories or images on the mental level, and finally as visions or insights on the spiritual level.

There are also distinct practices of dreaming body for the different natural elements, which, as mentioned before, express specific qualities on an energetic level. Vice versa the contact with the force can lead to the appearing of contents that indicate the presence of a shadow side connected to the element. In both cases, by remaining in contact with what emerges, the energy of the force becomes free to act and to liberate blocks or chronic states.

This aspect of contact with the subtle forces of the natural world differentiates the corporal practices of BTE from the Bioenergetic.

According to Lowen the interaction between *I* and *body* occurs through a dialectical process, in which *I* shapes the body through the control over voluntary musculature. In BTE the relationship is more subtle, as if body and psyche were interconnected expressions of the same energy (Lattuada 2008).

### Art of the gift of self

In these practices the psychotherapist acts using his/her hands on the body of

the client; it could seem a simple massage, but recalling the mudra-mantra-yantra integration, the purpose and the inner energy make a difference. Different movements are associated with the different forces of natural elements. For example, when the massage of the sea is performed, we are not talking only about the movement of the hands on the client's body, but rather about the subtle energy of an archetypal force expressing the qualities that belong to the water of the sea: everything comes and goes power of generation.

Also in this case also, the psychotherapist remains in a listening condition, of what comes either from the client and or in him/herself. These contents are not verified or interpreted; they only act as a sort of inspiration in order to guide the process.

### **Mindfulness practices**

Similarly to the psycho-corporal practices mentioned earlier, mindfulness practices allow to move from a state of consciousness typical of the dual mind to a unifying state of consciousness, in which the horizons of perception and comprehension extend beyond the boundaries of conscious experience. This is the therapeutic process itself.

In this state of consciousness it becomes possible to enter in contact with archetypal aspects of life; it's possible to transcend one's own personal biographical history.

Lattuada uses the term "*Keys of awareness*" (Lattuada 2012) to indicate different modalities to navigate the non-ordinary state of consciousness. They describe both a mindfulness practice and the therapeutic process that occurs during the practice. Hereafter I'll describe them briefly.

#### Passage from zero

Zero can be described as the source of being. To pass from zero means to become aware that we are already at the source, that we have always been there. Our Ego identification, our ego structures usually prevent us to realize this contact in ordinary life.

The starting point of this practice is the triad made of Force – Limit – Zero. The limit represents a block, as described earlier; the limit is what originated the block; by disappearing from it, through the practice of meditation, the force, understood as principle of healing, becomes free to act and restore the flow of energy.

#### Beyond the mind

This practice aims to accompany the client along the path that leads to the transcending of the boundary of the ordinary mind, in order to recognize the misleading reality based on judgment and identifications.

#### Further mode (MU)

Further mode represents the modality of knowledge that transcends the dual perspective.

Opposites are seen as expression of the ultimate reality itself. The first two most obvious opposite aspects we can experience are the weight of our body and the lightness of our breath. The first one brings us down, the second one can lead us upward. So the psychotherapist guide the client through this simple process until a unifying experience of being both a heavy body and a light breath can be realized.

#### Persistence of contact

When a block of the flow of energy has been identified, the client is invited to remain in contact with it, not to run from it or to look for explanations or interpretations. The aim is to encourage the person to live an inner experience of aware observation and compassionate love. Through this practice the primary cycle, observation acceptance awareness (see page 36), can be fulfilled.

#### 4 acknowledgements

This is a practice prior to any other. It recalls the four elements, earth, air, water and fire and it leads us towards the original dynamic, the dynamic of the two that becomes one, where opposites coincide and in the unity it's possible

to reach a state of consciousness, where it's possible to enter in contact with Self. The psychotherapist suggests through metaphor the contact with these elements. Earth: "I feel the physical body becoming heavy, what is heavy descends and earth receives it". Air: "Breath becomes light and circular, what is light rises towards the sky". The two processes occur at the same time, and so opposites merge in my experience and I realize the further mode in me, the state of the two that becomes one, the Tao, the state in which opposites coincide. In this state everything flows, and I let it flow (water), never ending, and I simply remain and observe (fire).

#### Mastery of Transe

It is the practice of "becoming the other". Through *captation* (see pg. 31) the client or the psychotherapist, based on the felt sense, can give voice to the block. Whether it's a physical symptom, an emotion or a memory, letting it to express will allow transcending the illusory separation between realities, that is how we perceive it, and its reality in a transpersonal dimension.

Through this practice the secondary cycle, contact mobilization direction transformation (see page 37), can be fulfilled.

#### Freedom from the known

Through this practice all the identifications born from traumas of our personal history are abandoned.

The client or the client is invited to verbalize everything that emerges into consciousness and then through a metaphor is invited to let it go.

#### Organism Transe

It's almost the sum of the previous practices. Once those identifications, attachments and character armors, have been abandoned it's possible to determine a state of re-harmonization of the different levels of Self.

These practices are suggested and started by the psychotherapist, according to the contents that emerge during the psychotherapeutic session. Generally the

starting point is MU (the further mode practice), then the psychotherapist starts stimulating the verbalization of the contents of consciousness, emerging at the physical, energetic and emotional level; he/she can also use metaphors in order to favor the modification of the state of consciousness, or use the magic words (see pg. 32), as mentioned earlier. Then the psychotherapist can work with any one of the other practice to induce what it is called either the primary or the secondary cycle. These are two ways to describe the therapeutic process.

Primary cycle: Observation, acceptance and awareness.

Observation means to explore blocks that cause a chronic Transe, live their experience during the practices; the acceptance of the contents that emerge, can lead to the awareness of what is experienced as a limit, the wound that events may have left are part of our personal history but can also be transcended on a transpersonal level.

According to BTE there is no need to explain, interpret or discuss. When the process of observation, acceptance and awareness happens in a non-ordinary state of consciousness the blocks causing a lived experience of discomfort and sufferance dis-solve, restoring a harmonic Transe.

Secondary cycle: Contact, mobilization, direction and transformation.

The contact with the contents that emerge on the five levels is the first step; then the psychotherapist favors a mobilization so that the process starts flowing again overcoming the blocks, in a direction that allows transformation. In this process the chronic Transe, the blocks, can be overcome. Also in this case, as the process occurs in a non-ordinary state of consciousness, there is no need of cognitive elaboration of the process.

As I said before, mindfulness practices aim to induce a non-ordinary state of consciousness, where it is possible to experience the true essence of Self. According to BTE, we could always have this experience, if we would not be overwhelmed by the contents of the ego mind, creating blocks, chronic states etc. Therefore the therapeutic process is aimed to let the contents of the mind fall down, the emotional reaction of our Ego to disappear so that we can be again aware of this contact.

In a non-ordinary state of mind the subject can listen to him/herself and perceive the feelings coming from the five levels (physical, energetic, emotional, mental and spiritual). The subject verbalizes these feelings and tries to remain in contact with them, so that, with the help of the psychotherapist, it becomes possible to notice the presence of the blocks or of chronic states. The psychotherapist can decide to intervene, with *magic words* (see pg 32) or touches, in order to help the subject to overcome the blocks, to favor a mobilization, and so a transformation. When contact with a block or a shadow is reached, transformation can manifest exteriorly as a cathartic process. Still, the process can favor contact with a force and lead to a passage towards the transpersonal where insights can occur.

Different practices can be used to explore the therapeutic process.

### Captation

It's a self-listening technique, an exploration of the deep. Once Transe is induced through the practice of the 4 acknowledgements, the client remains in observation listening to what emerges and verbalizing it.

It's important that the psychotherapist stimulates the client to verbalize the experience and re-conduct it to the five levels. Interruption can be a sign of a chronic Transe. In order to stimulate verbalization, clear questions are used (where, what, how); whereas, directing formulas must be avoided (does it hurt? Are you scared? Etc.).

A profound contact is important, so the person can be guided to explore the emerging experience as deep as possible. If h/she says: "I hear a scream", the psychotherapist can say: "scream"; if the topic is movement the psychotherapist can invite the client to move, or immobilizing the person favor a reaction to force him/her to move. The aim is to explore in depth, emphasizing what seems to have difficulty in emerging.

I would like to remind here that it is important that during this process both the psychotherapist and the client use the present tense and the first person to describe the experience.

There are several modalities that the psychotherapist can use to favor the

process during practice. These are:

### Dis-solving

It's important to keep in mind that it's not a choice between two alternatives, but it's from their union that the third way is born, allowing them to be transcended and included, so that the dualism can be dis-solved. When is possible to see shadow as a consequence of light and light as necessary for the shadow, it will be possible to understand both of them as occurrences of the same process, and so the eternal conflict between light and shadow will no longer exist.

### Expanding

If an archetype is present let it emerge, give it space. If it's accompanied by an energetic expression let it exit in every direction, as it's the force of the archetype asking to express. So if, for example, the client refers anger as a burning feeling, the psychotherapist might use a metaphor to introduce the fire and let the client face this anger.

### Navigating

If a feeling emerges go along with it, accompany it, navigate in it, and explore every aspect of it on the five levels. This navigation will lead you to explore the shadow or to the discovery of the place where the archetype expresses better its force.

If the client refers an experience of darkness the psychotherapist might invite him/her to explore this darkness through mental imagery.

### Prolonging

In this case a continuation along the path on which the process is blocked might be favored. In order to do so the person is stimulated with opportune questions. If h/she says "I don't know..." the psychotherapist might ask: "If you knew?" or "I'm still, I'm blocked..." "If you could go where would you go?"



### Becoming the other

Whether it's a subject or a feeling, give voice to it, represent it, also through drawing, or through body movements.

As I already said all these practices are meant to navigate through the Transe, the non-ordinary state of consciousness where the blocks to the energy flow caused by traumas from personal history, or by mental or emotional constructs, can be dissolved. Through this process a harmonic Transe can be restored.

## **2.3 Biotransenergetica - Epistemology**

A theoretical construct aiming to describe the complex psychological system of human beings and willing to describe operating mechanisms and possible “therapeutic” interventions, should be based on solid epistemological foundations.

As mentioned earlier transpersonal psychology focuses on the spiritual component of human beings. In general the aim of transpersonal psychotherapy is to favor an inner experience and enlightenment for a personal growth and for healing purposes (Walsh 1980). The attention to transcendence and spirituality causes a lot of criticisms from mainstream psychologists (Cunningham 2007). Other critiques come from the difficulty of a clear conceptual definition of transpersonal, mainly because these tend to be theory-landed and often based on ontological assumption about the nature of a reality (Cunningham 2007, Wlash 1993).

This is why I believe it's important to briefly report the epistemological references at the basis of BTE's reasoning.

In ordinary states of consciousness the mechanisms of knowledge are the ones described by cognitive science. From an epistemological point of view we are referring to theories that go from Aristotle and through empiricism and

positivism lead to the modern philosophy of science. All the various theories are based essentially on perceivable data and objective knowledge processes, which can be repeated and validated.

On the other hand, when we talk about non-ordinary states of consciousness, the states described in transpersonal psychotherapy, it's not possible to refer to the epistemological theories on which positivist science is based on.

A new epistemology has to be considered. There are two major authors, before Lattuada, that addressed this issue.

Wilber, talks about vision logic (Wilber 2000) referring to an ability to “move permanently into the higher realms”, or what he would call “subtle, causal and non-dual” state of consciousness. By gaining this ability to view rationality as a whole we can now transcend it. This transcendence is no mere detachment, but a greater embrace in which the previously disassociated spheres of matter, life, mind and spirit can be integrated.

Rowan (2011) talks about Third-tier thinking. The First-tier thinking is the most common level of consciousness, being based on formal thinking (Aristotelian, Newtonian, Boolean, and mathematical). Second-tier thinking is based on dialectical logic (what Ken Wilber sometimes calls Vision-logic). When we consider the spiritual dimension, we have to consider the Third-tier thinking. As Rowan says: “The essence of third-tier thinking is that we have to admit that we are spiritual beings. This means that we can have steady personal experience of this great realm, which Buddhists call the *sambhoga kaya*” (2011).

Lattuada talks about second attention. Whereas the first attention allows us to know the world through senses and rationality, the second attention is that modality of knowledge that allows us to understand reality, hidden behind “the Maya's veil” (Lattuada 2012 b). Lattuada distinguishes between Reality and Truth. Second attention allows access to reality, where The Science of Truth is concerned with inner experiences, which by their very nature are immeasurable and unique. Second Attention Epistemology considers that pure observation, pure sensation and pure action will allow us to transcend reality. First Attention perceives Reality, with which it identifies itself, Second Attention, instead, observes and dis-identifies itself from reality.

Even if with slight differences, all these modalities of knowledge are considered more suitable to explore the world of non-ordinary consciousness and transcendence.

## **2.4 Biotransenergetica - Science**

I conclude by underlining how, in the natural science field, BTE refers to that area of interest of neuroscience, which has studied in depth the interactions of the central nervous system with the endocrine and immunological system (Elenkov et al. 2004). These studies demonstrate how the system “human being” is a whole interconnected to the surrounding environment. External events may modify the system on different levels, and each level can influence the others. Therefore, the mind can also influence the endocrine and immunological system whether answering to an external stimulus or to an inner one, as for example a thought “that sickens”.

This perspective is supported by recent theory about bidirectional, top-down and bottom-up, interaction between brain and peripheral tissues, including immune, cardiovascular systems, through the endocrine system (Taylor 2010).

The external stimulus can be of a physical nature as well as of a social nature, if we consider the interactions with the people with whom we integrate.

Finally, the theories about the energetic aspect and the holistic approach find support in the theories of quantum physics. Even considering the different area of application, quantum theories are part of sub-atomic physics, here we are talking about applications in the field of humanities, some parallelisms can be found in the demonstration that matter and energy are expression of the same phenomenon and the idea of a consciousness that transcends physical boundaries.

From this perspective, following Bohr’s principle of consequentiality (Pauli 2006) mind and matter, consciousness and brain, can be considered as two complementary description of a single entity, none of which can be reduced to one another.

Another issue considered as a theoretical framework to support some physic state is the non-local kind of communication (Nadeau 1999). In quantum physic the entanglement describes how two particles originated from the same one will behave in an identical way even if they are in two different environments, far away from each other. Then a non-local mechanism might be a possible explanation of mental and physical systems.

These of course, are just possible approaches to apply theoretical structure to the phenomena of consciousness; it's not a way to explain such phenomena.

### **Concluding summary**

Through this brief overview of BTE theoretical background I tried to give an idea of the field I researched with this study.

Now we can get into the study, aimed to explore how non-ordinary state of consciousness works in a psychotherapeutic setting.

## **CHAPTER 3 - Research question and methodology**

In this chapter I will describe how the research question developed. In the first chapter I already showed, in a narrative form, how my development as a researcher influenced my approach to transpersonal psychotherapy, paving the way for this study. Here I will discuss it from the evidence based perspective, giving some literature references.

I will also discuss methodological issues, explaining how I arrived to choose a heuristic approach.

### **3.1 The meaning of Trance in psychotherapy**

During my training years and then during my clinical practice I became more and more interested to understand how the “mechanism of action” cited in BTE, actually works to therapeutic effect and can relate to self-development.

BTE methodology relies on a number of practices, described in several books by Lattuada (1997, 2004, 2005, 2008, 2012) explaining the theory and the therapeutic application of BTE.

However, here I am interested to study how BTE is really applied by other psychotherapists, working in different clinical settings.

In fact, since 2000 BTE is taught at master level, recognized by the Italian Ministry of Research and Education, and many psychotherapists now use BTE in a clinical setting.

The issue of clinical application of a psychotherapy model can, of course, applies to all psychotherapy. The medical field where I come from, bases every therapeutic practice, either pharmacological or surgical, on evidence based criteria. Clinical pharmacology, where I practiced for two years as resident during medical school, established rigorous and precise rules allowing proving the real efficacy of medicine.

As far as psychotherapy treatments are concerned there is a strong debate about studies demonstrating their effectiveness on an empirical base. Evidence Based Practice (EBP) has a long history in the medical field, going back to the

first clinical trial appeared in a 1948 issue of the British Medical Journal (Leff 2002).

In mental health this discussion started in the 1990s in Great Britain and then in the United States with the APA Division 12 which tried to identify empirically supported treatments (Chambless 1998). Numerous research studies using the bio-medical model of randomized-controlled trials have shown the efficacy of behavioral-cognitive psychotherapy, so that these treatments are now accepted as Empirically Supported Treatments (EST) (Tolin 2010). More controversial have been the results about psychodynamic treatments (Smit 2001).

However, there is a strong, sometimes harsh, discussion among professionals about the whole EBP issue, both for political and academic reasons.

Limiting this discussion to the latter, the post-positivism philosophy of science criticizes the “empirical myth” upon which the EST is based (Freire 2006). Some of the major limitation of randomized-controlled studies applied in the field of psychotherapy can be found in the paper by Elliot (1998). Back to 1968, Rogers (1968) considered the limitation of the mechanistic point of view when human beings are the subject of research, asking for a new kind of science. In 1985 he recognized that qualitative research methods could be the right answer (Rogers 1985). Since then many authors have applied qualitative methods to research in the psychotherapy field. According to McLeod (2001) qualitative data may help us to understand “what actually happens in therapy, what aspects of practice enhance or reduce outcomes, and what can be done to make therapy more effective”.

Qualitative methods are even more necessary when transpersonal psychotherapy is considered. Different authors have proposed various methods (Valle 1998, Heron 1996 Bentz 1998). Among these heuristic is particularly suited when the research focus is on the exploration of experiences which uses the self of the researcher (Hiles 2002). At an academic level the Task Force for the Development of Practice Recommendation for the Provision of Humanistic Psychosocial Services of the APA Division 32 (Humanistic Psychology) (2005) published a document presenting alternative

research methodologies in the field of human science in general and psychotherapy in particular.

From this perspective, the present study comes within the field of qualitative research, to provide a conceptual description of BTE practice based on its clinical application.

Conceptual description, as defined by Addis (2006) is a theory of both the etiological factors underlying a particular problem or disorder and the therapeutic change process.

The other topic of interest for this study is treatment manuals. A methodological description of the treatment itself is both an academic (Weerasekera et al. 2010) and health policy requirement. In 1979 a training manual by Becks et al (Garfield 1996) appeared paving the way to the development of validated psychotherapies. Of course, the use of manuals has raised a lot of criticism. Even if its importance in clinical research has been recognized, its validity in clinical practice has been considered with some doubts. It is generally accepted that manuals can be good if used as an instrument, in the hands of a “sensitive, creative and flexible clinician” (Addis & Cardemil 2006). Of course, practitioner’ skills, creativity and clinical judgment cannot be replaced by manuals.

A structural description of the application of this method in a clinical setting is necessary to identify what are the peculiarities of the methods and what depends on the variability of the psychotherapists.

As I already showed in chapter 2 the core concept of BTE is the *Transe* that is the state of consciousness. This concept describes the way we interact with the world outside us, including of course the interpersonal relationships. In a therapeutic setting this term refers also to the field of non-ordinary state of consciousness in which the psychotherapist and the client indwell during the session. Therefore, aim of this study is to describe the meaning of the *Transe*, the shared field of non-ordinary state of consciousness, in a therapeutic setting considering the psychotherapists and the patients lived experience during the psychotherapy session. From this description conceptual and structural aspects of BTE will be discussed.

### **3.2 Methodology: heuristic inquiry in transpersonal research**

The research question is focused on the meaning of the 'Transe' experience during the psychotherapeutic session, considering the psychotherapists' and the clients' descriptions.

A description of a lived experience from the participants' voice requires a qualitative approach (Cresswell 2007).

In fact, while quantitative methods are considered nomothetic, as they try to define general laws, universally true, qualitative methods are considered idiographic, as they seek to capture the unicity and complexity of the phenomenon under investigation (Dallos 2005). The former are methods to test hypothesis while the latter are suitable to produce hypothesis.

Qualitative research methods are based on philosophical ground, in relation to the specific research question and area of investigation.

There are different qualitative methods. Following Cresswell (2007) they can be grouped in narrative approach, ground theory and phenomenology. Narrative approach is grounded on history and anthropology, aiming to explore individual's life; from anthropology derives also ethnography, which tries to describe an experience in a group of people with a common cultural background.

Ground theory comes from constructionist and sociology and tries to develop a theory about a process observed in a special context observed from the inside.

Phenomenology, grounded on Husserl's philosophy is focused on the meaning of a phenomenon from a subjective point of view.

This classification of qualitative research approaches is a simplification as many more methods could be included and within the three major categories described here different methods have been developed for the various and different field of application.

As I already said aim of this research is to describe the lived experience of the 'Transe', i.e. an intimate experience, during the therapeutic setting. Even if the therapeutic process would affect individual's life, this was not the focus of the



research. Therefore narrative method could be disregarded.

Ethnography was not the case as the interest was not on the cultural effect or connotation. Similarly, grounded theory was excluded as the philosophical ground of the present research question cannot be read from a social-constructionist perspective.

Phenomenology seemed to me the best philosophical approach.

The term phenomenology, from the Greek verb “phainomenon” “appeared”, was first used by Husserl, to indicate a method of philosophical inquiry which would lead to a knowledge based on the individual’s lived experience (McLeod 2001). The object of study does not have to be real but it can also be in the subject’s consciousness. This method could be applied also to study the dimension of consciousness.

For Husserl the phenomenon has to be considered by every angle, setting aside all the assumptions in a process that he would call *epoche*. The goal of this process is to arrive at a transcendental domain of experience where the true essence of the phenomenon would become self-evident, so that it would be possible to have knowledge of the ultimate truth.

On this theoretical ground, Heidegger, Gadamer and Ricoeur (McLeod 2001), have developed phenomenology as a method of knowledge.

Different authors adapted Husserl’s original idea to research. As McLeod (2001) outlines there are differences between Husserl’s phenomenology and the way it is used by researchers in psychology. For Husserl it was not a method to study what another person or a group of people might experience of a phenomenon as his method was “ego logical”, grounded in self-reflection. The Duquesne method was developed by Giorgi (1985) in what is known as empirical phenomenology to be applied to social and psychology studies. In Giorgi’s method there is a lot of attention in the procedure to “bracket off” assumptions, as well as in the subsequent data analysis, in which the process of “condensation” is a key passage to get to the essence of the phenomenon.

Phenomenology can be applied in many different research contexts with different approach: hermeneutic, IPA, narrative (Creswell 2007). In any case, data analysis holds to the phenomenology position in the sense that through

the coding and identifying significant themes the researcher tries to arrive at the description of the essence of the phenomenon. In particular in the IPA approach the data analysis goes back to the hermeneutic approach of interpretation. From the phenomenology it takes the attitude to look at the data from all angles.

For Husserl the phenomenon has to be considered by every angle, setting aside all the assumptions in a process that he would call *epoche*. Similarly phenomenology applied to research, trying to describe the essence of a phenomenon, requires the investigator to bracket off his assumptions (Giorgi 1985).

The so called process of “setting aside” is a very critical one (Smit 2001). Some authors say that this is not really possible and they suggest that the researcher needs to be aware and place in the foreground their subjectivity (Colaizzi 1978). As Gadamer says: “Knowledge in human sciences always involves some self-knowledge” (in McLeod 2001).

The principle of bracketing off has been brought to the extreme consequences by Langdridge (2008) and other authors of the existentialist phenomenology, which use the term “demystification”. Some authors have raised criticism about bracketing off because cultural and social aspects, as well as empathy, memory, are considered “natural attitude” (Ricoeur, 1996). Others think that this process could inhibit replication. Others have raised the critique that this can be considered as neglecting social, historical and cultural dimension (Langdridge 2004).

In this study the researcher is the psychotherapist during the session and it would not only be impossible for the psychotherapist to take a stance from the *Transe* experience, but it would be a contradiction.

Moreover, phenomenology tries to reach the meaning of an event just as it appears whereas here I will try to understand the meaning of a non-ordinary every day experience from a subjective point of view.

For these two reasons I decided to use heuristic research methodology.

Heuristic is an internal search of meaning of a human experience and explicitly acknowledges the researcher involvement into the experience under

investigation, the researcher is therefore always present and visible (Douglas & Moustakas 1985).

Heuristic research methodology was developed by Douglas and Moustakas:

*"Heuristic research is a search for the discovery of meaning and essence in significant human experience. It requires a subjective process of reflecting, exploring, sifting, and elucidating the nature of the phenomenon under investigation" (Douglass & Moustakas, 1985, p.40).*

The method requires an indwelling and deep engagement with the research question:

*" . . . In heuristic research the investigator must have had a direct, personal encounter with the phenomenon being investigated. There must have been actual autobiographical connections" (Douglass & Moustakas, 1990, p.9)*

Douglas and Moustakas (1985) first described three steps of heuristic inquiry: immersion, acquisition, realization, further developed by Moustakas in seven phases (Moustakas 1990).

#### Initial engagement

The task of the first phase is to discover an intense interest, a passionate concern that calls out to the researcher, one that holds important social meanings and personal, compelling implications. The research question that emerges lingers with the researcher, awaiting the disciplined commitment that will reveal its underlying meanings.

#### Immersion

The research question is lived in waking, sleeping and even dreaming states. This requires alertness, concentration and self-searching. Virtually anything connected with the question becomes raw material for immersion.

### Incubation

This involves a retreat from the intense, concentrated focus, allowing the expansion of knowledge to take place at a more subtle level, enabling the inner tacit dimension and intuition to clarify and extend understanding.

### Illumination

This involves a breakthrough, a process of awakening that occurs naturally when the researcher is open and receptive to tacit knowledge and intuition. It involves opening a door to new awareness, a modification of an old understanding, a synthesis of fragmented knowledge, or new discovery.

### Explication

This involves a full examination of what has been awakened in consciousness. What are required are organization and a comprehensive depiction of the core themes.

### Creative synthesis

Thoroughly familiar with the data, and following a preparatory phase of solitude and meditation, the researcher puts the components and core themes usually into the form of creative synthesis expressed as a narrative account, a report, a thesis, a poem, story, drawing, painting, etc.

### Validation of the heuristic inquiry

The question of validity is one of meaning. Does the synthesis present comprehensively, vividly, and accurately the meanings and essences of the experience? This can be pursued returning again and again to the data to check whether they embrace the necessary and sufficient meanings. Finally, feedback is obtained through participant validation, and receiving responses from others.

According to Hiles (2001) the heuristic approach occupies a key place in transpersonal inquiry where not only ordinary human experience is considered but transcendent and exceptional experiences are elicited. Braud & Anderson (1998) have indicated heuristic inquiry particularly suited for research in the transpersonal field, not only for the direct involvement of the researcher into the field but even more for the recognized importance of personal knowledge

and tacit knowing of the researcher.

These aspects are very important in this study since the research question arose from my personal experience; moreover, the process of Transe during a BTE therapeutic session is an intimate experience for both the psychotherapist and the client so that it is not possible to investigate it without considering their involvement.

### **Concluding summary**

Having myself a strong academic and biological oriented education in psychiatry, I felt the need to provide a description of BTE based on a clinical study, not just on Lattuada's clinical experience and theoretical formulation.

Therefore, the present study is intended to examine how the psychotherapist and the client live the Transe experience and how this relates to a therapeutic and developmental effect. Aim of the study is to provide a conceptual and structural description of the BTE model, based on a clinical study.

Considering the topic under investigation, a lived experience of the non-ordinary state of consciousness during the psychotherapeutic session, and the degree of involvement of myself and the other parties (psychotherapists and clients), a qualitative approach following the heuristic method of inquiry was chosen.

Considering that I arrived at the transpersonal field from a biological approach, I consider myself as a bridge between two different perspectives. This position of mine gives me the sufficient critical framework, I dare to say the objectivity, to look at BTE without any prejudice.

## **CHAPTER 4 - Research project**

In this chapter I will discuss in detail the research project, on BTE clinical application, considering the methods and data collection. I will also discuss quality assurance methods and ethical issues.

### **4.1 Method: three levels of heuristic inquiry**

The aim of the study is to report on the clinical application of BTE not based on single case studies, or just only on my clinical experience. I am interested to consider a certain number of psychotherapist and clients. This would make it difficult to use a heuristic approach. However, as I discussed previously, I am so close to the BTE methodology, that it would not be possible to combine phenomenology with heuristic as suggested by Finlay (2009).

Therefore I designed three levels of heuristic inquiry. Figure 1, at page 57, illustrates the three levels of the heuristic inquiry. Psychotherapists involved in the study will be considered as co-researcher (TR), as they will be exploring the BTE experience from inside the therapeutic setting together with the clients.

The first level is during the therapeutic session, when the psychotherapist will be indwelled in the very experience of the Transe with the client. Afterward the psychotherapist will go through the explication writing the clinical records and collecting the data.

The second level is between the co-researcher and me as principal investigator (PI) during three meetings, when we immersed together in the lived experience of the data collection during the therapeutic session.

The third level is when as the PI, I went through all the data trying to reach a creative synthesis which will be comprehensive of all the complex experience. At this stage validation (as defined at page 60) was pursued first individually by the PI and afterward collectively with all the co-researchers together.

In Table 1 at pg 55 the seven phases of heuristic inquiry are shown along with the specific study design.

Initial engagement, for me has been already described in chapter 1. Then it was

discussed with all the TRs during a first meeting in which I illustrated the study in detail to the psychotherapists participating as co-researchers stimulating a discussion about the topic.

Immersion and incubation, together with illumination and explication occur during the therapeutic session with the clients, as the very process of Transe during the clinical session is already a heuristic process. These phases occurred also during three individual meeting between the co-researcher and the PI, either in person or via Skype, to immerse and indwell into the research focus, discussing the experience of the heuristic process of data collection. These meeting were audio-recorded and subsequently transcribed.

The lived experience of the heuristic circles was also considered in data analysis and discussion as integrant part of the study.

These phases have to be considered as a process, the only visible products of whom are the transcriptions, of the lived experience and of the meetings, and the creative synthesis I produced as a result of the explication phase.

The creative synthesis occurred first during the transcription of clinical and research data by the co-researcher and again during the monthly meeting.

At the end I went again through all the six phases reading all the texts several times, until themes emerged and I could develop a creative synthesis that would describe the essence of the experience.

In the text some extracts from the different transcriptions are reported and a full creative synthesis as discussion is provided.

**TABLE 1: study design**

<b>Moustakas's seven phases of heuristic research</b>	<b>1 Co-researcher and client</b>	<b>2 Co-researcher and PI + 1</b>	<b>3 PI + 1 &amp; 2</b>
<b>Initial engagement</b> The task of the first phase is to discover an intense interest, a passionate concern that calls out to the researcher, one that holds important social meanings and personal, compelling implications		The research question, already emerged for the PI . A first group meeting before starting the study will be held with the co-researchers, to favor their commitment and involvement.	
<b>Immersion</b> The research question is lived in waking, sleeping and even dreaming states. This requires alertness, concentration and self-searching. Virtually anything connected with the question becomes raw material for immersion.	During his/her clinical practice the therapist will go through these processes, either alone or during the session with the client	During the monthly meeting the co-researcher and the PI will immerse in the research question, exploring the experience from the therapist and the client perspective	The PI will collect all the data, the ones collected by the co-researchers during the clinical sessions, and the monthly meeting transcription. Themes will be identified by again going through all the phases.
<b>Incubation</b> This involves a retreat from the intense, concentrated focus, allowing the expansion of knowledge to take place at a more subtle level, enabling the inner tacit dimension and intuition to clarify and extend understanding.			
<b>Illumination</b> This involves a breakthrough, a process of awakening that occurs naturally when the researcher is open and receptive to tacit knowledge and intuition. It involves opening a door to new awareness, a modification of an old understanding, a synthesis of fragmented knowledge, or new discovery.			
<b>Explication</b> This involves a full examination of what has been awakened in consciousness. What are required are organization and a comprehensive depiction of the core themes.			

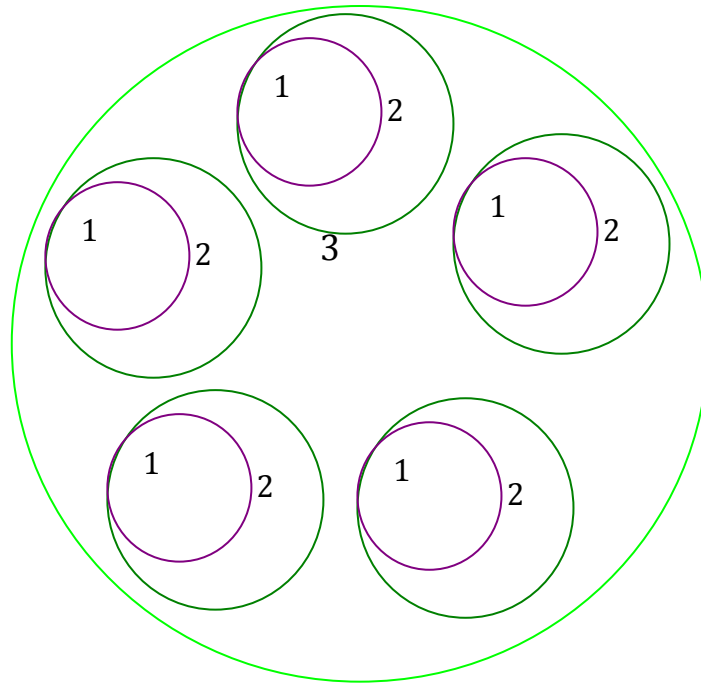
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<b>Table 1: study design (continued)</b>			
<b>Moustakas's seven phases of heuristic research</b>	<b>1 Co-researcher and client</b>	<b>2 Co-researcher and PI</b>	<b>3 PI</b>
<b>Creative synthesis</b> Thoroughly familiar with the data, and following a preparatory phase of solitude and meditation, the researcher puts the components and core themes usually into the form of creative synthesis expressed as a narrative account, a report, a thesis, a poem, story, drawing, painting, etc.	Co-researchers will transcribe the clinical records and collect the data as listed in the tables.	The PI will transcribe the audio-recording of each monthly meeting, taking reflexive notes about her involvement in the research project.	The PI will produce a creative synthesis of all the data trying to reach the essence of the experience
<b>Validation of the heuristic inquiry</b> The question of validity is one of meaning. Does the synthesis present comprehensively, vividly, and accurately the meanings and essences of the experience? Returning again and again to the data to check whether they embrace the necessary and sufficient meanings. Finally, feedback is obtained through participant validation, and receiving responses from others.			The PI will go back to the data again and again...
			The PI will go back to co-researchers as many times as needed until necessary and sufficient meaning could be considered reached.

**Table 1** This table summarizes the three levels of heuristic inquiry along with Moustakas's seven phases of heuristic inquiry (1990). The first level has place during the therapeutic session between the psychotherapist and the client. The second level, including the first one, has place during individual and collective meeting between me as Principal Investigator (PI) and the psychotherapists as Co-researchers. The third level, including the other two, has place when I analyze all the data collected in the other levels.

**Figure 1: three levels of heuristic inquiry**



**Figure 1:** a schematic representation of the three levels of heuristic inquiry is shown.

1. The first level is during the therapeutic session, when the psychotherapist will be indwelled in the very experience of the Transe with the client. Afterward he will go through the explication writing the clinical records and collecting the data.
2. The second is between the co-researcher and the principal investigator during the three meetings, when they will immerse together in the lived experience of the Transe by the psychotherapist.
3. The third is when the PI will go through all the data trying to reach a creative synthesis which will be comprehensive of all the complex experience. At this stage validation will be pursued first individually by the PI and afterward collectively with all the co-researchers together.

## 4.2 Data collection

As I already said, data have been collected by the psychotherapists, considered as co-researchers. Psychotherapists were enrolled through a recruitment letter (Appendix 2a, pg 160) explaining the aim and purposes of the study, including methodological and ethical aspects. All of them have successfully completed the four years master program, with at least three years of supervised clinical work after graduation.

Each psychotherapist enrolled one or two clients. Clients were informed by the psychotherapist about the purposes and method of the study, as described in the ethical issue section.

The psychotherapist collected socio-demographic data about the client and clinical data about eventual DSM Axis 2 diagnosis. If clients were treated with drugs the type, dosage and duration of treatment would have been indicated.

The presence of any acute or chronic organic disease, with the eventual drug treatment was recorded as well.

Any client could be enrolled in the study, regardless of the diagnosis or duration of the therapeutic relation. The observation for the study was planned to last for six consecutive months, unless the psychotherapy was ended earlier or the client wanted to interrupt the study (see ethical issue at page 61).

For each session the psychotherapists indicated, as listed in table 1 in appendix 3a (pg 165), the percentage of the total time he used BTE practices, such as body work, meditation practices.

The psychotherapist reported also the use of other techniques such as music, artistic expression (photographs, drawings, etc.) and body works different from BTE.

As I mentioned already, aim of the study was to describe the lived experience of the Transe, the field of non-ordinary state of consciousness, shared by the clients and the psychotherapist during the therapeutic session. At the end of each psychotherapy session the psychotherapist collected his/her own experience, as described in Appendix 3. S/He collected also client's lived experience of the practices, directly from the clients, and from the clinical

records. It was just a description without any analysis, interpretation or any further elaboration of the material.

As described in Appendix 3a, attention was paid to describe how the experience was lived at the five different levels (physical, mental emotional, energetic and spiritual).

Aim of the study was also to describe the meaning of BTE practices in relation to the therapeutic process. In fact, it is assumed that the practices, whether body work or meditation, are intended to produce therapeutic effect acting on the five levels (physical, emotional, energetic, mental or spiritual). The purpose is to describe how this effect is perceived subjectively by the client and objectively by the psychotherapist. This evaluation was done in three different moments: at the end of each session, after three months and after six months. This evaluation was performed separately by the psychotherapist and client as described in Appendix 3a.

At the end of each session the therapeutic effect might be at any level. It might be, for example, a relief of a muscle tension, or reduced pain or discomfort in some part of the body; at an emotional level it might be a reduction of anger or anxiety; at the mental level it might be an insight regarding a particular life situation or psychological issue. The effect may be perceived during the session or after a while; in any case it will be reported as explained in Appendix 3a.

The effect after three and six months may concern not only a reduction or disappearance of symptoms, but it might regard a wider area of clients' life, like significant relationships changes or overcoming stressful situations. In fact, as it has been reported by many authors, clients do not limit the success of a psychotherapy treatment to symptoms alleviation (Gallego 2005). It is important that both the psychotherapist and the clients separately fill this part of the evaluation, as a lack of congruence between the psychotherapist and the client has been reported in previous studies (Helmeke 2000).

Heuristic method of research, like every other research methodology, either qualitative or quantitative, requires quality assurance. In the next section I will discuss how this issue was considered for this study.

#### **4.3 Quality assurance: reliability, internal validity, credibility, dependability.**

One of the major problems of qualitative research is quality assurance. In quantitative research they speak about validity and reliability. The objectivity of measurements is granted by validation protocols. Also repeated measure is a way to ensure the trustworthiness of the results.

In qualitative research, where the object of research is a subjective experience, these concepts have to be reframed. As discussed by Morrow (2005), depending on the specific approach used in qualitative research new paradigm-specific criteria have to be redefined.

I was interested to describe the meaning of the Transe experience for psychotherapists and clients. In the study design I would base my analysis on their report. The quality assurance of this study therefore would be focused on reliability that is the trustworthiness of data collected and validity, referring to the trustworthiness of data analysis.

To pursue reliability as defined by Stiles (1993) particular emphasis was put on richness of description in terms of quality, length and depth of description of the experience. Stiles emphasize the importance of meaning of words, requiring the explication of investigator's personal experiences, context of the experience and so on. Even if these aspects would be limited by the common background between me as PI and the TRs, this issue was faced through a one-to-one discussion during the individual meeting.

Internal validity, has been defined as "isomorphism of finding with reality" (Morrow 2005, pg 251), and refers to an interpretation that is internal consistent.

For this reason I went back with the analysis of the data collected in a third meeting with all the TRs.

Another critical point of the study is the involvement of many subjects for a long period of time (six months). Therefore I had to pay special attention to what Morrow (2005) calls credibility as internal consistency.

Credibility refers to the internal consistency, "how we ensure rigor in the

research process and how we communicate to others that we have done so” (Gasson 2004). To this end it is important the prolonged engagement of all participants. For this reason a monthly meeting was held with all the psychotherapists involved in the study, asking them to send to me the material collected before the meeting so that I could check in richness of description. This served also to ensure reliability as I said before.

At last dependability (Morrow2005), that is the consistency across subjects and across time, in the conduction of the study, was assured, again, by the monthly meeting.

Dependability referred to the analysis phase was pursued by keeping track of the analysis process itself and by concentrating this phase in time.

I think that all the procedures adopted could give strength to the data from the quality assurance perspective.

I will end this method section discussing the ethical issues of this study.

In fact, like every research involving the psychotherapeutic relationship, also this study had to consider them carefully.

#### **4.4 Ethical issues**

Between the psychotherapist and the client there is an agreement of confidentiality so that the client feels at ease to share with the psychotherapist every aspect of his/her private and intimate life. This can be even more important when spiritual experiences are considered as they are so personal and secret. Even asking the client for his/her consensus to participate in the study has ethical concerns as they may feel in difficulty to refuse their consent for fear of losing the consideration of the psychotherapist.

Every study that researches what happens during therapy has a major risk of endangering the therapeutic relationship and breaking the agreement of confidentiality.

Following BPS recommendation (BPS 2009) an informed consent from the clients was obtained. Each psychotherapist was responsible for correctly

informing the client about the purposes and method of the study and asking for a signed consent to participate (appendix 2b pg. 162). The psychotherapist specified that in any case his/her name and/or any possible source of identification will not appear in the study reports; he will also explain that only those events or elements relevant to the study will be used. In any case the clients could at any time withdraw his/her consent without any compromise in the therapeutic relation; in this case all the data collected for the study will be destroyed. If the client feels uneasy to continue with the same psychotherapist, s/he upon request might be referred to a different psychotherapist.

To ensure the anonymity at every stage of the study an alphanumeric code was assigned to each client, where a letter corresponds to a psychotherapist and a number corresponds to the client. Only the psychotherapist knew the identity of the client and took care not to introduce any possible source of identification in the study reports. The PI knew the coding of each psychotherapist, but each psychotherapist would know only his/her own coding letter.

All the data were transcribed by the psychotherapist in a digital format. Each psychotherapist kept all the data in a safe place throughout the study, having a back-up. In the analysis phase all the data went to the PI that was responsible for their storage and back-up. At this point each psychotherapist would destroy any copy in his/her possession. S/he would continue to store only the signed informed consent form together with clinical records.

At the end of the study, after results have been published all the original data will be destroyed by the PI.

Psychotherapists participating in the study as co-researcher signed an agreement (appendix 2c pg 163) to comply with these ethical procedures. They also accepted to participate in all phases of the study including the monthly meetings. They were assured that they could withdraw at any time. In this case s/he would give all the data collected till then to the PI and have a last meeting with her to discuss the data, which can be used in the final analysis.

All the data were collected in Italian. Only the final elaboration was translated by a professional translator who signed a confidentiality agreement (appendix

2d pg 164).

Psychotherapists participating in the study as co-researchers have been formed at the school directed by Dr. Lattuada, and some of them are still in contact with him for supervision or continuing educational programs. Another ethical problem might regard the relation between the psychotherapist and the founder of the school, Dr. Lattuada, as some concern might be raised about possible fear of judgments by Dr. Lattuada on their clinical activity. For this reason Dr. Lattuada was not involved in this study at any time.



## **CHAPTER 5 – Data analysis: Explication phase**

In this chapter I will lead the readers through the explication phase. As described by Douglas and Moustakas (1990), this phase involves a full examination of what has been awakened in consciousness. Indwelling into the data an organization and a comprehensive depiction of the core themes can be reached. The *explication* phase is the analysis and organization of the data collected by the co-researchers. This phase took place in the third heuristic circles. Going through all the data collected by the TRs and the clients, along with the transcription of the meeting between myself and the TRs, I tried to extract the essence of the Transe experience.

The focus of the research was on the experience of the Transe by the clients and the psychotherapists, therefore I will consider the two experiences separately.

I also divided the experiences of the different meditation practices used, as they might have produced different experiences.

The aim of the study was to describe how the Transe works for a therapeutic effect; therefore I will discuss also how this effect was perceived by the clients and the psychotherapists.

I will also describe the heuristic process of the study for all the participants: myself as Principal Investigator (PI), the psychotherapist as co-researchers (TRs) and the clients.

### **5.1 Data description**

Both psychotherapists and clients have been informed about the purposes of this study and the modalities of data collection. All of them gave their consensus to participate to the study, collecting the material actively through interviews, and allowing reporting some information from clinical records if necessary for the study.

Ten psychotherapists were enrolled by letter (appendix 2a pg 160) explaining the aim and purposes of the study, together with methodological and ethical

aspects. Three psychotherapists dropped out in the first month, because they felt that the study required too much effort and involvement, both during the sessions and the meetings with me as main investigator. Data from these three psychotherapists were not considered as they were insufficient as far as the richness and quality of description were concerned.

Withdrawing of the therapist was considered a possible event. During a meeting I discussed with them, individually, their feeling and the patient's position about this and we agreed that they will correctly inform the patients. They gave assurance that this was not going to endanger the therapeutic relation.

The other seven completed the study. All of them have successfully completed the four years master program in transpersonal psychotherapy at the "Scuola di Formazione in Psicoterapia Transpersonale", in Milan, Italy, with at least three years supervised clinical work after graduation. In table 1 of Appendix 3b (pg 166) the psychotherapists' professional profiles are shown. The mean time of practice was 14 years.

Three psychotherapists were trained also in other psychotherapy approaches, psychodynamic, psycho-synthesis and transactional. 6 out seven were graduated in psychology; one was also medical doctor with a specialization in psychiatry.

A total of thirteen (3 male, 10 female) clients were studied. In Table 2 of Appendix 3b (pg 167) the clients' age and educational background is summarized along with duration of psychotherapy and their clinical diagnosis. Mean age was 35 years. All of them were native Italian, 6 of them had a university degree, and the others had a professional diploma. All the clients were in good health, none of them had a DSM Axis 2 diagnosis, and none of them was on drug treatment.

All of them turned to the psychotherapist because of personal stressful events, causing various levels of anxiety. A diagnosis of Anxiety Disorder (DSMIV criteria) was made for two of them; one had previous history of substance abuse (alcohol). Mean duration of BTE therapy was 11 months. Three of them already followed other psychotherapy treatment.

As shown in Table 3 of Appendix 3b (pg 168), a total of 121 clinical sessions using BTE were taken into consideration. When BTE practices were used it was for a mean of 67% of time of the psychotherapeutic session.

Table 4 of appendix 3b (pg 169) illustrates the practices used. More than one practice was used in the same session.

Usually one, either *4 acknowledgements* or *MU*, sometimes used together, would introduce the field and another, either a psycho-corporal or a mindful practice, would be used to *navigate* the therapeutic process. It must be said here that when the TRs had to report which practice they used there was a variety of different practice and they did not use a consistent terminology to indicate which of the awareness keys was used to conduct the therapeutic process.

This issue was discussed in detail during the meetings between me and the TRs, both individually and collectively, and an agreement was reached on how to handle the data. Therefore when I analyzed the data I grouped the practices as 4 recognitions, including also MU, as they were usually called, used to introduce the field. The mindful practices used to explore the therapeutic process were divided in *transition form 0*, also properly called, and *captation* to indicate a variety of mindful practices, all making use of this awareness key (described at pg 31), even if they were called with different names. Psycho-corporal practices and Mudra were considered separately. I will discuss this issue in detail as a critical point in chapter 6.5 at page 132.

The numbers provided in table 4 are intended to give an idea of the quantitative aspect on which the present analysis was carried on.

I evaluated all the material according to the heuristic approach. I divided the transcript according to the different practice used. Then I read the transcript several times, outlining how the subjects, either the psychotherapist or the client, would describe the experience on the different levels, mental, emotional, physical, energetic or spiritual.

From the description, based on their words, I tried to reach the essence of the experience. I will consider separately the psychotherapist and the clients. In fact from the psychotherapists' description a structural description of BTE can be reached, whereas from the clients' description a conceptual description of

BTE can be derived. I will discuss these aspects in the discussion section.

In the next sections I will invite the reader to indwell into the data, almost going through the explication phase as I lived it. I will show the data, and the core themes emerging from them.

## 5.2 Transe from the psychotherapist perspective

I will consider first how the psychotherapists describe their lived experience of the Transe during the psychotherapeutic session.

All the TRs describe a presence in the field involving them in a different way considering the various levels (physical, emotional, energetic, mental and spiritual).

All the psychotherapists experienced an involvement on a mental level, referring to what we described earlier as second attention (see pg 30 and 41), where a non- interpretational and non-judgmental listening and observational attitude prevails.

The words used by psychotherapists to describe their presence in the field are\*:

<i>I feel ...</i>	<i>B</i>
<i>I remain listening ...</i>	<i>E</i>
<i>I perceive ...</i>	<i>H</i>

\* The words written in italic are the exact words; each line refers to a different subject, identified by his/her code

Listening and observing are usually combined with “Not doing”

<i>I receive what there is allowing everything to flow</i>	<i>E</i>
<i>I remain and abandon time, a time without time and something happens</i>	<i>B</i>

The psychotherapist doesn’t intervene to suggest interpretations or associations regarding the contents verbalized by the client.

At most, as we’ll see further on, the psychotherapist verbalizes his/her felt

sense, or introduces the so called “magic words” (see page 32), in order to dissolve a block reported by the client or that he/she has perceived.

In fact, within this listening attitude the psychotherapists direct their attention also to themselves, understanding how what occurs in the field echoes inside them.

During the psychotherapeutic session sometimes mental content is combined with physical sensations:

<i>tension in the abdomen,</i>	<i>H</i>
<i>weight in the head</i>	<i>R</i>
<i>contracture on the left side</i>	<i>F</i>

Sometimes sensations on the physical level that have a correspondence on the emotional level experienced by the client appear, as the following example shows:

Psychotherapist R	Client 1
<i>Headache</i>	<i>anger, irritation</i>
<i>Headache</i>	<i>anger control, resentment</i>

In two cases the psychotherapist reported mental images regarding the client that somehow reflected the emotional and energetic content of the client’s process:

Psychotherapist R	Client 2
<i>Warrior</i>	<i>Charged and present,</i> <i>with the force of the impetuous winds</i>
Psychotherapist F	Client 1
<i>Warrior, lava</i>	<i>Container of something hard and hot,</i> <i>a lot of energy to conduct</i>

Two psychotherapists strongly participated also on a physical and energetic

level with a correspondence on the emotional level.

In the following example the physical and energetic experience of psychotherapist H and the emotional experience of client H1 are illustrated in parallel, as they occurred in a series of four consecutive sessions, in which psychotherapist and client worked with captation. In the first three sessions the TR didn't share with the client her felt sense. When during the fourth session the TR verbalized what she perceived, a cathartic process began in the client that led her towards awareness and an easing of the emotional experience of fear of rejection and discomfort.

TR H experience	Client H1 experience
I <i>Heaviness in the stomach, in the legs</i>	<i>Fear</i>
II <i>Fatigue, weight to the head, nausea, sadness</i>	<i>Weight in the legs as if they couldn't move</i>
III <i>Emptiness in the stomach, weight in the shoulders</i>	<i>Fear of rejection</i>
IV <i>Block in the shoulders, in the stomach</i>	<i>Inadequacy, anger</i>

The client in fact had talked about a feeling of inadequacy and consequent rejection by other people with whom she has an affective or even just a working relationship.

During the practices she reported various blocks on a physical and energetic level, and even though at the end of the sessions she reported a sense of clearness and lightness, the TR felt that a transition to a greater awareness had not occurred. This is why during the fourth session the TR decided to verbalize her physical experience and the client burst into tears and then exploded in a cathartic reaction that led her to express her anger in the session. So, whereas in the first three sessions there was "contact" with the block, in the last one mobilization and transformation in direction of anger occurred, completing what is called "secondary process" (see page 37).

In this case the psychotherapist's experience was that the client delegated to

her a role, to which the TR agreed, in order to allow the client to feel accepted and safe. Only later, when she felt that the client was ready, the psychotherapist stimulated the transition into awareness, avoiding the risk of the client perceiving an experience of rejection.

In the case of another psychotherapist (E), her perception of relaxation and flow was associated with a non-expressible emotional experience of sadness in the client.

The psychotherapist's attitude of observation and acceptance

*I form an alliance with her tears* E

facilitated the expression of emotions by the client, with tears that at the end left her:

*empty* E1

on an energetic level;

*calmer and cleaner* E1

on an emotional and mental level.

Other psychotherapists associated the mental level with the emotional one in the sense of feeling and accepting the emotion of the client:

*I feel very sad and very nervous* B3

*I receive and feel his pain.* B

Sometimes this observation happens on a more subtle, transpersonal level, as it doesn't directly recall the contents of lived life reported by the client, but rather concerns a wider dimension, transcending direct experience:

*In discomfort wellbeing, in lightness heaviness, in darkness light, in cold warmth, in solitude immensity.* B3

The participation of the psychotherapist has always been characterized by an attitude of accompaniment, never directing or interpretative.

For example in the case of a client that couldn't free his mind from thoughts during the practice of the 4 recognitions, verbalized with the exclamation:

*this mind sucks!!!*

B4

the TR intervenes only by inviting the client to recite a mantra, while she, remaining in the felt sense and in an observational state of second attention, observes:

*I stay instead of leaving, I enter in listening, in acceptance,  
in responsibility*

B

The client concludes:

*I realize that my mind is rebellious and it imposes excessively*

B4

Even in the feedback of the psychotherapeutic process, the psychotherapists never interpreted what emerged, leaving to the client the elaboration leading towards a process of awareness.

### **Concluding summary**

To summarize, we can say that in the BTE setting the involvement of the psychotherapist, following the model of an integrated and holistic approach, happens on all the five levels: mental, physical, emotional, energetic and spiritual. It is particularly interesting to note that the involvement at a physical level, expresses with physical and energetic feelings.

Of course the mental level is involved as well. However, it does not happen through what we can call the dual mind, that is the mind that looks for causative relation, the mind that rationally interpret and gives explanation; rather the psychotherapists use their felt sense and what Lattuada calls the II attention (Lattuada 2013) to observe the process.

Most of the time the psychotherapist just observes what happens, without doing nothing else than keeping the field as a safe place for the client to express his/her lived experience and to follow the psychotherapeutic process.



### 5.3 Transe from the client perspective

Now I will consider the clients' descriptions. The data are coming in part from the clients' description of their lived experience at the end of the session, in part from extracts from the clinical records.

The BTE session is characterized by a first phase of relaxation, to create the field, the Transe, in which the psychotherapist and the client indwell together. This is usually done, using the 4 acknowledgements or the MU. During this practice, depending on the contents emerging from the client and resonating to the psychotherapist, the psychotherapist might continue with another practice. Sometimes however, these two practices might be enough to lead the psychotherapeutic process to an end, just for the session.

I will consider the different practice separately, as they have different theoretical and practical background as I discussed in the previous section.

#### 4 recognitions - MU

The four recognitions refer to the four elements: earth, air, water and fire. During this practice the psychotherapist guides meditation firstly by suggesting the sense of weight of the body and inviting the subject to abandon it; then the TR suggests lightness of breathing, inviting the subject to follow it; afterwards the TR invites the subject to observe what happens inside him/her, recommending the metaphor of the incessant flow, while the aware attention remains focused on observation.

At the beginning of the practice the mental contents prevail. During the practice the clients verbalize the presence of thoughts, usually described as disturbing:

*Too many thoughts in my head, they crowd, close me\** B1I

\* The words written in italic are the exact words reported by the clients; each line refers to a different subject, identified by his/her cod, the Roman numerals refer to the session number.

*People, images, things that happened during the week, they all  
annoy my mind... words heard, or said, they all leave a trace in my mind* B3II  
*Thoughts run over me* B4I  
*Thoughts are the most difficult obstacles, they put a pressure  
on my forehead* B4 IIIa

Other times the emotional contents prevail,

*Sadness emerges ...* B3 IV  
*Anger grows at the highest level ...* B4 II

Usually associated with energetic or physical elements:

*I feel myself empty, sad and fearful ...* B3 IV  
*I feel a fear at a physical level, it's in the pelvis....* H1 II  
*I feel a fear as a feeling of cold and a block at  
my back and lumbar region* B4 IIIb

In both cases mental and emotional contents are often reported as experienced in third person, as if the subject was filled with them, invaded, from the outside, not as if he/she produced and felt them.

In these descriptions an integration of the physical level with the other levels might be observed. In fact during the practice there is a reference to the weight descending, therefore bringing the attention to the material body, so that during the practice the material body becomes mediator of the energetic and emotional level.

When describing emotions of fear and anguish patients would associate them to the following physical feelings:

*I feel like my legs cannot move* H1IX  
*I feel a heaviness in the stomach* B4IIIc  
*I feel a block in the movement of the arms* H1 XIV  
*I feel a torsion in my neck a heaviness on the chest* H1IX

Whereas, the emotion of *anger* would be associated with feelings in the legs described as:

*I feel a void it is like if my legs cannot keep still...*  
*an irritability in my legs* B3 V

Or in the throat:

*I feel like I want to scream crying, but I cannot, I wish*  
*I could but I feel my throat closed, it is like if something*  
*in my throat is squeezing, I need to take something out* B2I

During the practice thoughts might also be described with physical aspects:

*The mind causes a blocks in the neck* H1 XIII  
*Thoughts weight in the head* B3II  
*Thought are like a bubble around the head* F1IIa

As the practice continues, the integration of the content, either mental or emotional or both together, at the various levels brings a different awareness of the content itself, leading to a change of the subjective state, described as:

*I feel warmth* B4IV  
*a few kilos less* H1XIV

In other cases a state of inner peace appears.

*an illumination in each cell* F1IIb

In a few cases an insight occurred, showing the other side of the coin

*I was in a closed space of the room; now I can feel the breeze*  
*of the morning wind, the noise of the waves from the sea and*  
*the whiz of the wind on the mountains; from the dark night*  
*to the bright dawn. From fear to freedom* B3V

*I felt empty, sad and fearful; now I feel I am at the source,*

*you are the source*

*B4IV*

These insights are reported not just referred to whatever problem was discussed before the practice, but as something referred to the subject's life in general.

To summarize, as mentioned at the beginning, during the 4 recognition and MU while the subject is in a state of profound relaxation the psychotherapist solicits an aware observation of the flow of contents that emerge to consciousness. I believe we can say that the description in third person comes from this observation of the flow. This lead to a lived experience of dis-identification from the content, both on a mental and an emotional level. This observation from the outside is also associated with the integration of the emotional and mental level with the physical one.

When the two processes of dis-identification and integration fully occur, there is a shift toward a lived experience of wellbeing and in some cases transpersonal level can be reached with insights as the last examples show..

### **Transition from Zero**

This meditative practice is characterized as being at the source of the Self. The psychotherapist suggests through a metaphor the state of being zero that is to say to be empty of contents. The client is invited to verbalize any content that might emerge on any level, and through a metaphor is invited to return to the source.

During the practice the clients started verbalizing mostly mental contents, thoughts either as not interfering with the meditation:

*Thoughts outside the circle* *B4III*

*Thoughts flow freely in my mind, I feel quiet, I can let them go* *B4VIII*

*the mind is not so full of thoughts* *D1V*

*the mental state is clear* *B2III*

Or as disturbing:

*The hell this mind... leave me alone... go away* B1I

Sometimes feelings on a physical level are reported, such as:

*I feel heaviness, tension, I cannot let myself to go completely* B3V

Associated with an emotional experience of fear:

*I fear to let me go....* B3V

As the practice goes on they are transformed into a disappearance:

*I disappear in the body* B1I

If at the beginning there was a perception of:

*I feel like I have rigid and big hands* B4III

at the end the perception would become:

*I am round and soft* B4III

Other times the emotional content prevails, and their connotation is brought back to the physical and energetic level

*I feel sad and confused, like if I have a big weight in the chest* B4X

*I feel fear, like if I feel heaviness and rigidity* B1I

*I feel fearful, it's like a void* B4III

The practice guides the clients to return to the source, when this transition occurs completely it is described as:

*Passing from chaos to quiet* D1IV

*I don't perceive him/her as an enemy anymore, I get closer, he gets closer, and we can be together,* B4VIII

*I accept you as you are, and as I am.* B1I

It is possible to say that this practice is characterized by a detachment from

either the mental or the emotional contents.

In the two last examples we can see how personal life events reported earlier in the sessions as source of tension and discomfort, are resolved through what is called primary process of observation-acceptance-awareness (page 36). The event has not been object of treatment in the practice. Meditation at zero is a way of reaching a detachment from the ego identification allowing the subject to widen his/her vision in which tension, discomfort, can be transcended, to get in touch with the Self.

Whereas in the practice of the 4 recognitions described earlier this occurs through observation from outside of the contents connected with the personal history, here it happens through a detachment from those contents.

### **Captation**

This practice, which usually follows one of the previously described practices, is used to explore blocks that eventually have emerged. It's characterized by a profound contact with what emerges on the five levels, allowing the expression of these contents both verbally and through non verbal communication at the emotional level.

Even if during the practice the client was invited to use the first person to describe the experience, at the end of the process he/she uses the third person to describe the experience. It is like if, being in a different state of consciousness; the subjects don't recognize what happened as something coming from them.

The following examples will show this for the contents of the mind:

<i>my self-depreciation stood in front of me,</i>	<i>B4VI</i>	
<i>I was astonished when I enter these thoughts</i>	<i>E1II</i>	
<i>I don't not know why I wrote certain things</i>	<i>B2IX</i>	
<i>even if it hurts, I don't oppose what comes</i>		
(referred to mental content)	<i>E2 IIIa</i>	
<i>it's hard for me to recognize and abandon some of my mechanisms</i>		<i>E2 V</i>

Or for emotional contents:

<i>Tears surprised me</i>	E2II
<i>As if there was another person able to smile at me</i>	B2IX
<i>I didn't think that recalling that image could hurt me so much</i>	E1I
<i>I feel like crying, it never happened to me before, I don't know what it means to feel like crying, but it means I'm feeling what I'm doing.</i>	E2IIIb

By remaining in contact with what emerges, thoughts are transformed in insights and expressed emotions give a sense of:

<i>Cleanness, peace, tranquility</i>	B4VII
--------------------------------------	-------

Insights seem connected to a change of perspective, for example we see the following changes from the beginning to the end of the practices:

B4IX

- *"I don't want... I don't want to be submissive, I don't want nuisances, I don't want this situation*
- *"I want": to feel what I am, do what I want, I feel I can.*

H1VIII

- *I feel weight in the chest; get to feel the weight... I feel overloaded with work imposed by my supervisors*
- *I feel a sense of duty; without that weight ... I would feel like a nullity, incapable*

E2III

- *I need to adapt to the image of the "perfect woman" in the eyes of the men I have been engaged with...*
- *Are my own eyes looking at me...*

In this practice the process of the detachment from the contents seems to be

crucial, and through the change of perspective what is called primary process of observation-acceptance-awareness is realized (see page 36).

This process is described on a more profound level, rather than on a cognitive mental one:

R1II

*- There is always something I come to understand, that I didn't understand before, or something that I sensed and now It's confirmed.*

X1 VII

*- I already knew it before, but now it is as if I know it with my whole body.*

In other cases what is called secondary transformation process (see page 37) occurs.

For example, in one case, contacting emotions associated with some thoughts:

B2VIII

*- Thoughts tighten my head, images increase my anger, my mind keeps on thinking and being angry,*

and letting them express, in this state of Transe,

*- That's enough I can't take it anymore, let's put an end to this, go to hell, disappear from my horizon, if you were here I would push you around until you tumbled over, get out of my thoughts, leave me alone, leave, leave,*

allowed to contact a transpersonal level and finally the client concludes:

*- Self tells me to let go, to stay in my place, to do what concerns me, and the then rest will be what it's meant to be. A deep breath and I feel the silence, I feel my place, everything is in the right place, I'm in my place, I'm in my place, this is how it is.*

In another case, the client who felt pressured by the requests of the family:

B2 IX

*- my mother ... my father ... my brother ... my brother ...*



during the practice was able to contact a level in which she feels

*- outside these borders, I fly on these waves, I go towards the sky, I lay on the clouds  
and travel.*

*Finally I feel free and aware.*

At the end she described the therapeutic process with a drawing showed in  
figure 2 in the following page.

What I want the most is  
Intensity and reality

CONGRUENCE  
INTEGRITY  
FLEXIBILITY  
TO STAY



**Figure 2:** We can see the graphic description of the process experienced by the client in which she becomes aware of her place, next to the fire, with her feet on the ground, in contact with the experience of the Self, as it was experienced during the psychotherapeutic process.

In the secondary, as well as in the primary cycle, the psychotherapeutic process occurs not at a cognitive level. The awareness comes through the emotional level and expresses more on a transpersonal level as case I and II shows using either a verbal form or a picture.

The core themes emerging from these descriptions are about dis-identification from mental and emotional contents and integration of the physical, energetic, emotional mental and spiritual levels.

A change of perspective was also observed, which would favor overcoming biographical history.

We can say that when, during the practice, the possibility to get in contact with the transpersonal level is created, and the contents of personal history can be observed from outside and transcended. We can say that the contact with the Self leads to “healing”, understood as dissolution of the blocks causing the state of discomfort.

### **Psycho-corporal practices**

#### **Body of the dream**

As described in the introduction, the psycho-corporal practices can be movements and gestures to be performed keeping the attention to what happens not only in the body, such as painful reactions or stiffness, but also at a psychic level, meaning the mental and emotional level, as well as at a transpersonal level meaning visions or insights. In BTE this is called Mudra-Mantra-Yantra integration.

The *body of dreams* is a sequence of movements that the client performs, guided by the psychotherapist. During the movements the psychotherapist solicits contact between the different levels, inviting the client to move fluidly and incessantly, with no interruptions even when having difficulty. In fact difficulties, which are an expression of a block in the flow of energy, must be verbalized so that with the psychotherapist's help these blocks can be dissolved, through the psychotherapeutic process.

Obviously, during the practice the physical component prevails in the description, usually as a pain or a difficulty in the movement. The attention to the other levels brings different contents either at the mental or emotional level. As the following examples will show persisting in the movement and staying in contact with the emerging contents something happens.

B2III

*I feel a pain in the base of the spinal column*

*I am annoyed by R's nonsense*

*I can let the thoughts and R.s image to fade away, I am not only this, I am infinite,  
and I can be the source...*

B2V

*I feel a pain at the base of my spine, like a tension*

*P's thought disturbs the quiet*

*I feel that my body is opening, the pain is melting*

*In the movement some passages of silence*

B3V

*My back is tired; there is a tension in my cervical spine*

*My father's image comes to my mind it's difficult to get rid of it*

*I feel dismay like if I have been betrayed*

*Trust is like a blue space, fear is black like a night without the moon*

The change towards a resolution of the block does not always happen.

In one case this attitude represented an expression of a modality typical of the person:

B4II

*I don't feel confident about the movement, I have to check*

*I feel like a cold shivering along the spine*

*I can't let things happen, I feel the need to watch myself to see if I'm doing well, I  
perform the practice with the mind.*

*When I can't manage to do what I want or want I'm told to do, I get angry with  
myself and I start to misjudge myself.*

In another case, it concerned the psychotherapeutic relationship.

H1X

*I cannot move my neck and my head*

*I feel I am not good enough, I want to be proud of myself, I want the psychotherapist to be proud of me...*

When the psychotherapist notices that the client strongly focuses the attention on the correct execution of the movement, the psychotherapist invites the client to:

*Feel the movement of the body*

As she hears these words the client starts crying silently and verbalizes an experience of attention seeking and approval from the TR.

Whereas sometimes no difficulties emerge since the beginning

*B2VII*

*In the movement I can feel myself, and I allow myself to let go... I enter in my body and the movement guides me and brings away everything*

*Everything around me is quiet I feel like I can fly*

From these descriptions, it is possible to say that the integration of the physical level with the mental one leads to a greater awareness not only of the body, but also of the contents related to the other two levels. Observation, stimulated by attention to the integration with the mental and emotional levels, allows the content to be seen from outside, detaching from them. This way the primary process of observation – acceptance - awareness – can be realized. This might allow the client to reach a state of wellbeing.

## **Mudra**

As explained at page 32, the term Mudra is used to refer to movements impregnated with an archetypal quality. These practices are typical of a transpersonal approach as a subtle level is evoked. Of course, it is not just a belief system; it is rather the non-ordinary state of consciousness that allows the client to “surrender” somehow to the inner energy related to the Mudra. The psychotherapist invites the client to assume a position, or to perform movements suggesting through metaphors the qualities they refer to. For

example the metaphor of fire can be used when the client is dealing with anger and rage:

*Fire from the deep...*

F1I

*My body is something dense, warm*

*I felt a lot of energy to conduct*

*I felt like a fire,*

F1III

*There is a tension on my left side*

*I feel like I am passing out*

*I am afraid I could explode*

The metaphor of the sea can be used when for the client is difficult to let go some situations or feelings:

*Sea: everything comes and goes*

R2I

*letting sensations of the past history that hurt*

*me go away*

*create space for something else*

The metaphor of metal when some strength as to be reinforced

*The force of metal*

X1 VII

*inflate from the inside,*

*a line of tension crosses the belly, but the head*

*is free, the heart calm. Go to hell, damned*

In the third example, the subject of the practice was a client with difficulties to express his feelings, not only in behavior but also in words, and even in gestures. The psychotherapist asked him to portray himself, using a camera, expressing emotions of joy, anger and sadness; in the images produced he always had the same mimicry, as he had already noticed himself before attending the sessions. Because during the session he reported an episode that irritated him, he was invited to enter in contact with the anger that he was

feeling, and crying down on himself unable to express it (*“if she offends me it’s because I’m not worth anything”*); on a physical level he experienced this situation as a block in the stomach. When the psychotherapist made him assume a position of firmness and contact, through the metaphor of the armed warrior, the client verbalized what is reported in the text, in part adapting his mimicry and gesture to the content he was verbalizing.

In the following session the client said that when his partner insulted him again, he reacted firmly, verbalizing his unhappiness. This surprised both him and his partner.

### **Concluding summary**

From the descriptions of the Transe experience two major themes could be observed: dis-identification from the mental and emotional contents, and integration of the five levels (physical, emotional, energetic, mental and spiritual).

These two processes would trigger the primary and secondary cycles. That is the observation-acceptance- awareness, and contact-mobilization-direction-transformation.

Sometimes these two cycles would lead to a transpersonal experience, allowing the client to look at his/her biographical experiences from another perspective. From the experiences reported by the clients it is possible to say that working in a non-ordinary state of consciousness, integrating the physical level with the spiritual level, in what is described as Mudra, allows the quality of the energy to trigger a change of perspective so that personal history can be left and the subject can get in touch with a transpersonal dimension.

In some cases psycho-corporal practices seem not to lead to an integration of the five levels, and this happens when in the subject an attitude of judgment on what he’s doing prevails during the practice.

### 5.3 Transe in the healing process

Aim of the study is to describe how the Transe relates to the psychotherapeutic process. In fact if we speak about therapy each practice is supposed to have a psychotherapeutic effect. For this reason the psychotherapists and the clients were asked to report on their lived experience of the Transe in relation to the psychotherapeutic effect. This had to be described at the end of each session and after three and six months. Here I will go through the clients' descriptions, considering separately the perceived effect at the end of the psychotherapeutic session and after three and six months.

#### Clients' description at the end of the sessions

At the end of the session, the emotional level is where the healing process has been felt mostly, through feelings of tranquility and serenity:

<i>I feel calmer</i>	D1
<i>I feel clear, relieved, comforted</i>	F1
<i>I have a feeling of serenity, joy, fluency in movements</i>	B2
<i>I am serene</i>	H1

Other times it was expressed on the energetic level.

Both in the sense of emptiness and lack of energy, seen in positive terms due to the disappearing of physical or emotional tensions:

<i>I feel like emptied from the overload of energy</i>	E2
<i>I got rid of some heaviness, I abandoned it</i>	H1
<i>I needed this outburst, I felt like a pressure cooker</i>	E1

And also in the sense of energy charge perceived as positive:

<i>I found it energizing</i>	E1
------------------------------	----

Energy that is perceived as useful in order to face both the psychotherapeutic process and life outside the psychotherapeutic setting:

<i>It seems as if I met this force inside me</i>	F1
--	----



*I feel like a dragon capable of confronting the world* F2a

The perception of the psychotherapeutic process on a mental level regarded a greater clearness of what happens in the person and of awareness of one's own being:

*I understood some things* H1

*There is a clarity of mind regarding what to do* B3

This awareness can also concern relationships with others:

*I feel like I'm abandoning that armor I built to defend myself from the world, to be stronger, that armor that on one side that protects me, but that suffocates me on the other. E1*

Sometimes awareness concerns not just one's own psychotherapeutic process in the strict sense, but also a process of personal evolution:

*More aware, but also bigger question marks, as if awareness created other question marks E2*

*I caught a glimpse of the way, but the way must be travelled F2b*

*More determined to love myself, to respect myself B2*

Awareness was often present also in association with the emotional and energetic experience:

*I feel very well, I feel clean F1*

*I had the feeling of throwing out through breathing what is not needed anymore F2*

*I feel in peace, with a feeling of warmth in the chest B2*

The physical level was generally used to describe the emotional, energetic and mental levels:

*I feel I'm able to let tension go, even if it is difficulty, it's an emotion to have a body I can manage. B3*

Obviously, the description of the experience related to the psychotherapeutic

process isn't always positive. Sometimes negative feelings were reported:

*I have headache, I feel a fatigue R1*

*I feel physical tiredness and pain caused by what I saw in the psychotherapeutic process R2*

*I feel confused, with vertigo D1*

*I feel confused but aware of the transition towards a sense of responsibility E2*

*I feel exhausted due to the challenging psychotherapeutic work E1*

As these examples show whereas during the practice the subjects would refer to the contents of the body feelings, thoughts and emotions in third person, now the subjects seem to use the first person again, and, sort of speaking, repossess both the positive and negative experience.

Often emotional and energetic contents are associated with the physical ones, as if this association improved awareness.

We could say that the stimulus, solicited and learned during the practices, to observe and integrate the different levels, becomes something automatic, used also outside the practice.

We must underline how, on the other hand, the mental connotation is expressed only in cognitive terms, even though during sessions the cognitive level is never solicited.

#### Clients' description after three/six months of therapy

The psychotherapeutic process was evaluated also after three and six months of study. Data will be considered together, as therapy sometimes ended after three months. The psychotherapists and the clients gave a separate description. In table 5 of Appendix 3b (pg 170 and following) I reported the transcript of clients' reports together with the psychotherapists' reports.

Here I will discuss the description in more details, considering first how the experience is described by the clients.

The clients reported an improved level of self-awareness. This can express as an ability to observe body reactions and feelings:

*Then I started to feel and move having greater perception of my  
body and a greater ability to identify tensions and blockages in me* B3a  
*I started to feel my body ... as never before* E2

Or in more general terms as an ability to “listen”:

*I feel cleared, with a clearer head* F1  
*I can be present in a different way* R1  
*I have developed basically the ability to see and move in  
difficult situations* B2  
*I listen to myself more* E1  
*I allow myself to listen, they talk to me about things that  
happened or about fears, I listen to them again and again* B1

This self-perception brings to different attitudes toward themselves:

*I started to let go my feelings without judgment, with greater  
understanding and acceptance* B3  
  
*I realized that this is the essence of my being and that all those situations  
in which I experienced discomfort were coming from a lack of choice and  
because I was missing a loyalty to my feeling* B2  
  
*I am able to take care of myself* F1  
  
*I think I can be successful as I am more lucid and able to think by myself  
I perceive a greater stability of identity, of knowing what I want and to plan  
my life. I feel more courage* H1

There is also an improvement in the ability to perceive their own emotions:

*I understood how my thoughts, both the positive and negative ones, were able  
to change very effectively my physical and emotional state.* B3  
  
*I observe my emotions, I do not go away, I stay there, I welcome them, as they*

*belong to me, are part of myself*

B1

Being able to recognize one's own emotions allows observing them and recognizing them also in others:

*There's a greater communication with him (boyfriend) than before; ...  
when we had fights before I used to think that it was because he did not love me,  
now I understand that he is not doing well, it doesn't mean that he does not  
love me enough*

E1

The ability to self-listening and expressing emotions with more awareness changes the relationships with other, so that the feeling of being forced to surrender disappears; this lead to a change in behavior perceived also by the others:

*Others are bewildered and as if it understand that the real me is coming out,  
because there are more fights, but I'll take this in a positive way because  
if this aroused in others, it means to say that I'm going more for what I am ..*

E2

There was also a change of perspective concerning one's own life, as expressed in the sentences:

*Memories of past episodes and thoughts that keep me awake the night of the session  
I saw my life past and present and put it back in order with  
the new way of seeing things*

X1

*As if all the bad things, the betrayals, the tragic things they had not left their mark.  
They have marked and influenced me all my life, so it's a totally new thing for me.  
This is the strongest thing that I feel as if I wiped them out.*

F2

*I don't feel pleasure anymore in things that were rewarding for me before,  
I feel improved*

E2

*I started to identify old modalities of thinking, habits, which in time  
became useless and that I used to face life issues. My mind, used to*

*control, especially when I lived with my parents, helped me not to go crazy ... it gradually stepped aside, allowing trust and joy of life to emerge.*

B3

We can even observe a change in the relationship with those who hurt the client in the past. A traumatic event caused the client H1 to be confined to the role of victim for life, making her complain even if at her own expense. At the end of the 6 months therapy she describes such a person in her past as:

*Now I can see him as a fragile person*

H1a

Resentment and anger that don't dare to be expressed and that oppressed the person with guilt, become a feeling of hate towards that person, but on the other hand as they find a direction along which they can be expressed, they free the person, who feels the possibility to live again:

*Through the practices I could catch a glimpse of the possibility to break the framework that makes me think of me as a fearful and hesitant person, makes me feel free.*

H1

And after six months of therapy she describes herself as:

*Full of energy, willing to undertake many activities and tell her own story through them.*

H1

From these descriptions it can be said that the psychotherapeutic process would express as an improved awareness, with greater capability of listening to one's self and others. It was also described a change of perspective through which it was possible to look at personal past events with a different attitude. Where once there was self-pity, now there's awareness; where once there was resentment now there's acceptance.

While reading extracts of the sessions I was surprised to see how some personal history events, which in BTE psychodynamic model represent blocks in the flow of energy, have not been faced directly, but rather observed during the process of Transe, as if it were from outside, as if it the observer was the

transpersonal Self.

We can say that those events have been dissolved because of this process; that is to say that the blocking effect of those events disappears. This is what in BTE is called to go beyond personal history.

Contact with a dimension beyond the personal level, through archetypical representations or meditation practices, allowed attachments to personal history, which often conditioned the subject's behavior in the sense of self-pity or opposition, to be let go.

#### Psychotherapists' description

The healing process was described also by the psychotherapist. As it is outlined in the table 5 in appendix 3b, in general the perception of the psychotherapeutic process coincided with the client's perception. Some psychotherapists also noticed variations on a physical level:

<i>The mimicry is more mobile, and congruent with the emotional contents;</i>	
<i>the sight is more direct.</i>	X1
<i>Movements have become more fluid, more personalized</i> (referring to movements during the practices of the body of the dream)	H1

Often a reference to a greater individuality emerges, understood as the ability of individuals to see themselves not just in relation to others but also as autonomous beings:

<i>She listens much more to his/her own needs and individuality</i>	E1
<i>She wants to continue therapy in order to face some intimate aspects not related to others.</i>	E2

Often this process is seen in relation to the confrontation with one's own shadows:

<i>The client feels less fear in accepting part of the self in the shade, such as anger, fear of intimacy, emotional closeness.</i>	H1
<i>An integration of anger occurred, even if the need not to feel it sometimes persists.</i>	B3

This allows the psychotherapist to see:

*Greater assumption of responsibility in favor of a personal self-assertion.*

B4

Considering the psychotherapeutic process in general, we can say that the greater awareness of the clients was expressed towards the outside, as if individuals engaged a greater emotional and mental autonomy in their relationships. Obviously this is not only perceived by the psychotherapist, as some examples show, but also by individuals who have relationships with the clients, changing the relationship itself.

This awareness seems to be related to the constant process of integration between the physical, emotional and energetic levels.

Furthermore, by constantly changing the point of observation from internal to external, the subject can look at his/her personal history from a different perspective. Sometimes the point of observation is beyond the personal level and in this case the inner transformation is more profound.

The process through which these steps occur is almost never on a cognitive level and often at the beginning the subject feels disorientated; nevertheless, this allows a deeper implication of the person.

Some mechanisms of the psychotherapeutic process, first of all the integration of the physical level with the others, are interiorized, and the subject puts them into effect also outside the psychotherapeutic context.

Even the capability of changing point of observation, practiced during sessions, becomes part of the subject's relationships with others and with life events.

### **Concluding summary**

From the description of the perceived therapeutic effect it seems possible to say that at the end of the therapy there was a subjective feeling of well being, expressing mainly on the physical, energetic and emotional level.

After three and six months, there was a perceived improvement in self-awareness at every level.

This would allow the subjects to have satisfying relationships and a feeling of being more able to realize themselves.

The psychotherapists' reports were similar, as they observed more awareness and self-determination in the clients.

## **5.5 Heuristic circles**

At this point I'd like to describe the experience of the participants in the study in relation to the heuristic process of the method.

In the heuristic method the researcher involvement is crucial, and given the topic of the study, an inner experience of non-ordinary state of consciousness, this method was the best fitted.

However, considering the design with many psychotherapists and clients involved, with one investigator to analyze the data, it was necessary to create three different levels, as described in the method section at page 52.

As far as myself is concerned, I went through different phases.

At the beginning I was really excited to start. Once that everything was ready, having defined the method, including quality assurance and ethical issues, I sent out the enrollment letter, and spoke with the psychotherapist to further explain the study. This phase has been quite challenging as many colleagues answered with enthusiasm at the letter but only thirteen of them came at the first meeting, and ten were the ones who decided to participate.

As I already said three of them quit during the study as they found it too heavy. This was disappointing me, and I found very engaging to keep in touch with the other co-researchers, motivating them. However, during the study, in the first two months the TRs participating started to feel more and more committed and noticed some positive effect of the study for their clinical practice. Then everything went on very smoothly. Even if it has been quite a job, it was really exciting too. And finally the TR collected good data for the analysis and the analysis itself was exciting too.

Considering the first heuristic circle, involving the clients and the TR, it is important to underline that the clients felt really involved in first person. In



some cases, as they chose a transpersonal psychotherapist due to a specific interest in this field, they were enthusiastic to participate. Two of them directly expressed their experience with these words:

*- I am glad and enthusiastic to subscribe, happy to have the chance to collaborate with the expansion of transpersonal psychology, to which I am strongly attracted to and interested in. B2*

*- I am very interested in this research because I believe it's real and I gladly participate. I'm interested in BTE and I gladly collaborate with the study. B3*

I believe that these considerations are important to point out the clients' implication in the research not as "object" of study, but rather as active subjects. As a matter of fact, as I will discuss further on, the patients should have been considered as co-researchers as well.

Another client expressed her appreciation for the study, which has been an integral part in their therapy, (see figure 1 in Appendix 3b pg. 175). Other two clients asked if it would be possible to know the results of the study. For this reason I prepared a brochure, discussed in the research outcome chapters, showing the results of the study for the patients.

Considering the letter showed at page 175, acknowledging my presence, and in general the degree of clients' involvement in the study, I think that it is possible to say that, one-way or another, my presence has been felt. They knew that all the data were going to be analyzed by me as PI. This further justifies my decision to use a heuristic approach.

As far as the second heuristic circle, including myself and the psychotherapists, is concerned, it took place through a series of encounters, some in person and some from a distance, but always with a constant involvement both from the technical point of view (how to gather data), and supporting TRs who especially during the initial phase were aware of the study.

I already said how engaging it was for me to keep in touch with the TR motivating them and coordinating and assisting them in the data collection

phase. I was also committed to keep this second level of heuristic circle alive through motivation and engaging with them.

On the other side, all of the psychotherapists, showed interest in the study, sharing a common interest in BTE as a relatively recent psychotherapeutic model, needing some sort of validation, and so this study can be considered as a necessary preliminary study.

It's important to underline that all the TR reported how dwelling into the experience of the sessions resulted useful also from a psychotherapeutic point of view, whether in order to better understand the client's process or to review their own experience as psychotherapists

As two of them would say:

*It was really helpful for me to go through the data, to understand better  
what was happening during the psychotherapeutic session* F

*I find it helpful for me to check what I was doing. From the feedback  
from the patient I could adjust myself in the next session* E

During the second collective meeting, at the end of the data collection phase, all of them repeated that they were really happy to have participated to this study.

Some of them had the impression of being part of something wider than their usual psychotherapeutic activity:

*I was pleased to participate, as I had the feeling of being part of a wider circle* R  
*I think this is absolutely necessary for BTE* D

In the third level, including the other two, I worked alone for the analysis phase, immersed in the material. This phase of immersion and incubation, reading the material reported by the TRs, was extremely fascinating. It was like entering the intimacy of the client's experience that told their personal history, it almost felt as if I was attending the sessions, participating in the suffering that some clients were experiencing.

Reading the texts led to a first division based on the different practices used.

The more I read the more topics chaotically swirled around in my mind. Then slowly they started to group, almost spontaneously, drawing attention to some physical experience associated with a certain emotion.

Thoughts that in the initial phase of the practices seemed to be omnipresent started to fade away, leading to insights like a flash, and sometimes leaving the space to a transpersonal dimension.

It was as if even I, similarly to the TRs in session, had to remain listening through the second attention, allowing the contents to manifest. Only later I began to organize them, looking for confirmation in the text in order to perform a more orderly and formal analysis.

At the end of the explication phase I wrote a creative synthesis and sent it out to the TRs. There was a general agreement with it, no major critical issues were brought by them.

### **Concluding summary**

The degree of involvement by all the participants, clients, TRs and I, is in favor of the heuristic approach.

The heuristic design of this study proved to work well, as all the participants, seemed involved at different times in the different circles.

This method allowed all of us to collect the experience of the Transe during the therapeutic process.

## **CHAPTER 6 - Discussion: Creative synthesis**

As defined by Moustakas (1990), in the creative synthesis the researcher describes the components and core themes as a narrative account, a report, a thesis, a poem, story, drawing, painting, etc. In this particular case I will organize them in the form of a discussion, trying to give a conceptual and structural description of BTE model.

First I will consider the use of non-ordinary state of consciousness as a healing practice.

From the data analysis about the meaning of the Transe during the therapeutic session two themes emerged: dis-identification and integration. I will discuss these two as the basis for BTE conceptual boundaries.

From the psychotherapist description of the field two themes emerged: the presence of the therapist in the session and the physical dimension in the setting. I will discuss these two aspects as structural boundaries of BTE model. Acknowledging my educational background in neuroscience, conceptual boundaries will be considered from this perspective, reviewing evidences from literature about mindfulness practices and their effect on brain function and structure.

BTE structural boundaries will be compared to other psychotherapy models, especially gestalt and bioenergetic, from which Lattuada was particularly inspired.

I will also discuss some methodological aspects, considering heuristic inquiry as a valid tool to explore non-ordinary state of consciousness in a therapeutic setting.

At the end I will analyze some critical points about the study in general and BTE in particular.

## **6.1 The meaning of Transe as a field of non-ordinary state of consciousness in a psychotherapeutic setting**

As I explained in the introduction Transe describes the field of state of consciousness shared by the psychotherapist and the client (Lattuada 2012).

This non-ordinary state of consciousness can be induced by meditation practices through which the patient is invited to focus his/her attention to the physical body and what happens on an energetic level.

Before entering the discussion about the meaning of the Transe, I would like to discuss the non-ordinary state of consciousness from a psychological and neuroscience perspective.

First of all it is important to define the concept of non-ordinary state of consciousness, starting from the definition of consciousness.

From a neuro-physiological perspective consciousness is a primary function and activity of the brain. Two main different states of consciousness can be identified: awake and sleep. These states have precise and specific neurophysiologic characteristics, described mainly by brain electrical activity registered by electroencephalography (EEG). The reticular activating system in the brainstem is the area responsible for the electrical activation of higher structures in the brain, through the thalamus-cortical system.

Consciousness has three different behavioral components: arousal, which describes the person's ability to interact with the surroundings; awareness of internal and external stimuli, which in clinical terms is indicated by time and space orientation and by self-orientation; attention, which depends on awareness, and describes the ability to respond to a particular type of stimuli.

Each one of these has a specific brain network, starting from the thalamus and connecting with cortical areas with higher level of complexity.

Different pathological states have been described, extremely various in their clinical expressions, both regarding the level of arousal, awareness and attention.

Regarding arousal, its compromise causes different levels of coma, characterized by specific EEG pattern, going from those in which the subject

is awake but there is no awareness, described as vegetative coma, to the worse where there is absence of electrical brain activity, and brain death can be declared.

As far as awareness and attention are concerned their alterations can be described in a variety of forms: oneiric like, dissociative or crepuscular states.

Pathological states can be caused by numerous and various factors. These can be endogenous, due to metabolic or electrolytic alterations causing a change in the functioning of the central nervous system, or exogenous, induced by psychotropic substances: alcohol, hallucinogenic substances, etc.

Far more complicated is the definition of state of consciousness from a psychological perspective. Initially William James, embracing Darwin's theories of evolution, defined consciousness as a mechanism allowing human beings to adapt to the environment (Durrant & Ellis 2003).

Afterwards, when neurophysiologic studies started to clarify the mechanisms of perception, consciousness was referred to these functions.

It was with Watson, in the Behaviorist Manifesto, that the study of consciousness was banished from the psychological field, substituted by cognitive processes and observable behavior. As he stated: "Psychology as the behaviorist views it . . . is a purely objective experimental branch of natural science. Its theoretical goal is the prediction and control of behavior. Introspection forms no essential part of its methods, nor is the scientific value of its data dependent on the readiness with which they lend themselves to interpretation in terms of consciousness" (Watson, 1913 in Fuchs 2003).

Philosophers, as well as neurophysiologists will keep on dealing with consciousness intended as self-consciousness, interested in understanding its expression through the study of brain activity. The studies performed by Sperry, among the others, lead to the formulation of the materialistic theory, in opposition to the theory of the dualism-interactionism sustained by Eccles and others (Eccles 1983).

Along this line, by integrating brain functional studies with cognitive science, neuroscience was developed. The most extreme evolution of this would result in neuro-phenomenology, which tries to ascertain the relation between

consciousness and the nervous system combining the method of phenomenology and neuro-science (Varela 1996).

Talking about consciousness, in general we can state that consciousness is understood as awareness both of the world and of inner processes.

As far as transpersonal psychology is concerned, we should talk more in terms of states of consciousness rather than simply consciousness, involving all the variable conditions of awareness. Interest in the study of states of consciousness remained alive in some fields of psychology, especially in clinical psychology, with a special attention to phenomena connected to states of consciousness observable in shamanic trances, in oriental meditational practices or in Sufi. Medicine and mainstream psychology usually tag those states as pathological or altered. When in the sixties the active principle of mescaline was discovered and LSD was synthesized in the laboratory, the study of the effects of these substances on the state of consciousness and the possibilities to use these substances in a psychotherapeutic setting began. In 1970 the Controlled Substance Act stopped clinical research activity on the use of LSD. Therefore, the study of non-ordinary states of consciousness continued through the use of practices such as breathing or meditation. To describe one of these breathing techniques, which by inducing a state of metabolic alkalosis causes modifications of homeostasis of the cerebral tissue, Grof (2013) introduced the term holotropic state of consciousness. The neologism holotropic is formed by two Greek words: *holos* meaning whole, and *tropic*, from *trepo/trepein*, meaning “moving towards”; this state of consciousness helps us to recognize that “we are commensurate with the cosmic creative principle itself.” (Grof 2013 pg. 93).

In general, transpersonal psychology defines as non-ordinary states of consciousness those states in which the subject may experiment a transcendent level of reality, a sense of unity with external phenomena. From a psychological point of view those experiences aren't the product of fantasy or of pathological processes, but rather expressions of archetype materials or collective unconscious. Some authors proposed theories to support the ontological reality of transpersonal experiences (Ferrer 2002, Tarnas 2006).

Even if the research on psychoactive substances in a psychotherapy setting recommenced more recently mainly in life-threatening diseases (Gasser et al. 2014) and post-traumatic stress disorder (Mithoefer et al. 2010) in the last decades of the past century, mindfulness practices inducing a non-ordinary state of consciousness were introduced in the field of cognitive/behaviorist psychotherapy and as a support treatment for some medical problems as well. There are many empirical studies describing the effect of mindfulness on many different diseases in which a correlation between stress and inflammatory response was first hypothesized then demonstrated (Bonadonna 2003). So meditation has proved effective in rheumatic chronic illnesses, such as LES (Young 2011), in inflammatory bowel diseases (Schultz 2013), in cardiovascular diseases such as hypertension (Ospina 2007). It seems that in contrast to medication, acting only on the inflammatory reaction or suppressing the auto-immune response, meditation acts on the emotional reaction to external stimuli, which in turn activates the adrenocortical axis responsible of the inflammation symptoms (Pace 2009). A similar effect related to stress reduction has been found also for meditation and pain control (Zeidan 2012).

The same mechanism of meditation on stress response and mood modulation has been used by CBT to control anxious response in some psychiatric diseases. Strauss (2014) in her meta-analysis study analyzed twelve studies using a randomized control trial design in different psychiatric diseases going from anxiety disorders to bipolar and depression.

This study shows that using mindfulness based intervention, within a context of cognitive psychotherapy or person based cognitive psychotherapy there was a reduction of the level of symptoms severity, leading to a significant improvement for both depressive and anxiety symptoms (Strauss et al. 2014).

I'd like to mention also some neuro-scientific studies that investigated the effects of mindfulness practice on the central nervous system.

As I said before, each state of consciousness has a peculiar electrical activity in the brain. Some authors studying the effect of meditation on brain electrical activity reported that meditation is associated with a prevalence of theta



activity, associated with a deeply internalized state and with a appeasing of the body, emotion and thought. (Gruzelier 2009).

However, there is not only a functional effect, as anatomical modifications have been observed as well.

Lezar et al (2005) showed that meditators have thicker gray matter in the right anterior insular than control subjects. In the same area a change in gray matter density was observed in association with perceived stress reduction after mindfulness (Holzel & Carmody 2010). Other areas of the brain involved in meditation are the right orbital frontal cortex and right hippocampus. The first area is involved in emotion regulation and expression, whereas the second one is involved in modulating reaction to chronic stress. These evidences could justify the hypothesis that non-ordinary state of consciousness frees the subject from the influences of emotional reactions. Being aware of emotional reactions, not controlling or inhibiting them, would help to dealing with them better.

Moreover mindfulness training is associated with changes in gray matter concentration in the brain regions involved in learning, memory process and attention (Craig 2009). This is in agreement with some studies demonstrating that attention is a factor to distinguish between novice and trained meditators (Hozel & Lazar 2011). Finally I would like to mention the study by Allen (2012) that reported evidence of executive related neuroplasticity in short mindfulness intervention. These data would support the hypothesis that meditation can give access to a different mindset to approach and interpret reality.

Considering all these studies it is possible to conclude that inducing a different state of consciousness might induce functional and anatomical changes, suggesting the idea of neuro-plasticity. This is a new perspective to look at the positive effect of meditation on different cognitive process and mood regulation (Davidson 2003, Nielsen 2008).

At this point is important to underline that, a substantial difference between the use of mindfulness practices in these settings and its use in transpersonal psychotherapy. According to cognitive-behaviorist psychology, mindfulness

practices are an intervention strategy (Shapiro 2006) not related to a conceptual theory about disease and therapeutic process. Whereas, in transpersonal psychotherapy the aim of these practices is to induce a state of consciousness in which the subject can contact a transpersonal dimension, overcome personal biographical history, realize the unification of the different levels of one's own being (physical, emotional, energetic, mental and spiritual). It can be said that such a state is the therapeutic process itself, because the so-called problems, psychic disorders and symptoms are part of the personal level. Contacting the spiritual level and integrating it in one's experience means accessing a dimension in which disease doesn't exist.

In BTE, as it has been described already, different meditation practices can be used to induce such non-ordinary state of consciousness. Even more, these practices create a field, shared by the psychotherapist and the client, where they can work together in connection also with a transcendental dimension.

When the subjects participating in this study reached a sense of integration of the five levels and were able to overcome their personal biographical experience, they often described a sense of inner peace and unity with wholeness (see examples at pg. 82 F1IIIb and pg 74 B4IV). This experience was giving them a sense of relief from the tension that brought them into therapy. Integrating these, so called, spiritual experiences in their personal everyday life, would give to the patients a different perspective, a wider frame, to understand their life, some of them also reported that they felt more committed towards the fulfillment of their own goals (see examples at pg. 88 F2b and B2, see also examples at pg. 90). This is why transpersonal psychology and psychotherapy talk about evolution of the individual rather than healing (Lattuada 2012). Evidences coming from the cited studies speaking about the neuroplasticity associated to meditation are in support of the transpersonal vision of psychotherapy as an evolutionary process.

In BTE meditation practices, described in details in chapter 2, are the 4 recognitions, MU and zero. They are usually used at the beginning in order to introduce both the client and the psychotherapist into a non-ordinary state of consciousness. In such a state it's possible to access what Lattuada calls second

attention, in which a process of knowledge, not based on cognitive mental elaborations, but rather based on the felt sense, takes place. This is similar to other meditation practices, which, in their variety, all report a state in which “enlightenment” (White 1974), “revelation” (Wise 1974), “heightened awareness” (Jevning & Wallace 1992), might be elicited leading to a process of knowledge not based on a cognitive process.

Furthermore, in this state it’s possible to access a trans-personal dimension, in which contents of the mental and emotional experience are seen from a perspective that overcomes and transcends personal biographical history. The other practices, called keys of awareness, occurring in this state of non-ordinary consciousness shared by the psychotherapist and the client, have a more specific therapeutic purpose.

In agreement with the transpersonal vision, also BTE considers the healing process as a transformation process of the consciousness. The mindfulness practices are not just a therapeutic tool, rather they might be considered as a therapeutic process leading to a transformation of the consciousness, from a chronic Transe, that is a state of consciousness characterized by identification, to a harmonic Transe, that is a state of consciousness in which we can recognize our true self as dis-identified from any biographical event or emotional reaction, or intrusive thoughts. From the neuroscience evidences we can formulate the hypothesis that this transformation involves not only the psyche but also the brain from a functional and structural perspective.

I would like to end this discussion with a last consideration. Brain structural abnormalities have been searched in the brain of psychiatric patients since the beginning of psychiatry as a medical science. More recently brain imaging techniques gave new evidences of many and different variation of gray and white matter volumes in the brain of various psychiatric diseases, from schizophrenia (Farrow 2005), to bipolar disorders (Brambilla 2005).

More recently longitudinal studies have considered the effect of medication on brain structure, demonstrating that some changes in brain structures related to the limbic-cortical circuits may be reversible (Jarnum 2011). Similar finding have been reported by Ahdidan (2011) and Anacker (2011) in patients with

depression treated with antidepressant drugs. Similarly, Szeszko (2004) reported a reduction in the left amygdala volume in obsessive compulsive patients treated with paroxetine, a common antidepressant. Therefore the therapeutic effect of psychiatric drugs is not limited at the neuro-receptor level; there are more and more evidences of functional and structural changes as well.

However, there is a main difference between medication and mindfulness practices: the former act from the outside, without any awareness by the patients, whereas the latter ones act from the inside, requiring a continuous effort and commitment by the subject. The same difference could apply to the use of psychedelic substances in association with psychotherapy. (Carhart-Harris et al. 2012). Unfortunately there are no studies, published so far, to my knowledge, comparing these two different approaches.

In any case, the involvement of subject in mindfulness practices is, in my opinion, one of the strongest points in favor of the theories considering psychotherapy as an evolution process of the consciousness, in which non-ordinary state of consciousness may play an important role.

## **6.2 BTE conceptual description: the meaning of Transe in a therapeutic setting**

Conceptual boundaries can be considered as a theory of both the etiology factors underlying a disease and the therapeutic process. BTE model is based on a theoretical construct developed by Lattuada, this study is intended to see if these theories could describe what emerges from the clinical data.

As mentioned earlier, aim of this study is to describe the meaning of 'Transe', in a psychotherapeutic context, based on the psychotherapists' and patients' lived experience. The lived experience of the 'Transe' has been collected by the psychotherapists and the patients and analyzed by myself.

Now I will discuss those aspects of the 'Transe' emerging from the analysis of the data.

As previously described in detail, the effect of the practices occurs essentially on two levels: **dis-identification** that is detachment from the mental and emotional processes, which are observed from the outside and let go, and **integration** of the physical level with the emotional, energetic and mental ones. I will discuss them separately.

### **Dis-identification**

At the beginning of the practice the patients referred to mental contents as something coming from the outside. They were described in third person, often as disturbing not as much because of the content rather for their intrusiveness (see pg. 72 B1I and following).

During the practice and at the end of it, thoughts were let go and a detachment from their emotional connotation was reported.

A similar effect regarding the emotional content was also observed. In this case if during the practice there were lived experiences of negative emotions, at the end of the practice they were described in third person as something observed from the outside (see pg 78 E2II, B2 IX, E1I, E2IIIb; or page 73 B3Iva, B4II). Describing this detachment, the patient would report a sense of relieve of the tension and anxiety which were present at the beginning of the session. Even more, through this process the patients could find a different perspective to look at life events connected with the stressful situation they were living and sometimes they could even reach an insight, through which a new understanding was possible (see pg. 78 H1VIII e E2 III).

In general the therapeutic process was associated with perceived improvements of their subjective state of wellbeing, not only at the end of the session but also as a general outcome of the therapeutic process, described as clearer mind regarding whatever problem brought them to therapy.

Being able to detach from the experienced emotion would also lead to improving in the ability to recognize others' emotional states and acknowledge their behavior (see pg. 91 E1 e E2, pg 92 H1a).

This process would happen usually during the self-captation practices. Even if during the practice the experience was lived in first person and in a “here and

now” dimension, at the end it would be described as it was lived in third person. It seems that through this therapeutic process a different perspective about personal stressful events could be reached.

I think that this process can be compared to a similar effect observed by many studies exploring the application of meditation in psychotherapy.

This effect, first described Teasdale (2002) and called **decentering** describes the process of being aware of one’s experience with some distance and dis-identification.

Decentering is defined also as viewing internal experiences with increasing objectivity (Feldman et al. 2010), responding to internal and external experiences with less emotional reactivity (Shapiro 2006); negative thoughts and feelings are seen as events passing in the mind rather than reflections of reality (Lau 2006).

Many empirical studies about mindfulness applied in different clinical problems, including anxiety, binge eating and binge drinking, depression and self harm behavior, described decentering as the main determinant effect. (Nolen-Hoeksema 1991). Some studies showed a decrease in rumination among individuals receiving mindfulness training compared to control subjects (Jain 2007). This effect has been found to be both a state (Lau 2006) and a trait (Carmody 2009) effect.

Different kinds of mindfulness practices have been associated with decentering (Feldman 2011), such as mindful breathing, progressive muscle relaxation and loving kind meditation. The effect has been related to the increased awareness of ruminative thought, consistent with the principle of exposure training.

Another possible explanation has been related to decrease emotional distress associated with negative repetitive thoughts (Feldman 2010).

In BTE dis-identification is not just a therapeutic tool, but it represents the therapeutic process itself. The block in the flow of energy might lead to identification with a mental construct or an emotional reaction, causing the perceived psychological sufferance. Identifying with anger or fear, or with the mental construct of regret, we will allow that emotion, or thought, to drive our own life, to see everything and everybody through those lenses. As long as the

subject is identified, however, he/she cannot see what is really happening; he/she has to step back, to embrace another perspective.

Dis-identification means realizing that emotions and thoughts are not the person but the experience. When the subject is able to set him/herself free from this identification the block can be recognized and overcome.

The life event and the experience associated with the block are part of the personal history. Very often the identification with the associated emotional reaction would crystallize the subject in a specific role inside that history. Aim of the psychotherapeutic process is to favor a dis-identification process from these lived emotions allowing the person to regain the control of his/her life. This process of dis-identification from the emotional connotation can be considered also from the neuroscience perspective that shows how mindfulness practices affect brain structures involved in emotional reaction, mainly the limbic system (Gruzelier 2009, Holzel 2010), as discussed in the previous section.

Di-identification from the emotional reaction is considered important also in other psychotherapy model, such as gestalt and Bioenergetic; what is peculiar in BTE is the way this process develops in a non-ordinary state of consciousness, that is without involving the cognitive level. Moreover, reaching insights and living spiritual experiences, as the patients refer when they have feeling of unity with a transcendental dimension, would help the subject to recognize that the personal level is not the only one in which we can express and develop.

This reference to a transpersonal dimension is what distinguishes BTE from other approaches that deal with dis-identification.

What is important for BTE is that identification is not just a symptom, it's the pathology itself, and this trait distinguishes BTE from other approaches. Therefore, guiding the client towards dis-identification isn't the symptomatic effect, but the healing process itself.

Letting go of one's personal biographical history can be achieved through what we described as primary cycle and secondary cycle (Lattuada 2012).

The primary cycle consists of a three phases: observation, acceptance and

awareness. The first step is observation: the dis-identification allows reaching a new perspective to look at an event or at an emotion from the outside. Acceptance of what happened is possible when the emotion associated with that lived experience can be overcome. Usually, when we are identified with an emotion, we are driven by it, so that, for example, we might react to an offence with another offence or a sense of guilt. When the emotion can be overcome and the event is observed from the outside, a different perspective can be reached, so that we can be aware that we are not just the victim with the only possibility to react or to suffer; we can be aware of whom we are regardless of what other people might do to us.

The secondary cycle consists of four phases: contact, mobilization, direction and transformation. Once that a block, expressing at any of the 5 levels, has been recognized, the subject stays in contact with it. This means that no explanation, interpretation or judgment is suggested nor requested. The psychotherapist helps the patient to mobilize the block using different practices, to favor the eliciting of restrained emotions, disclosing of hidden thoughts or expression of unsaid words. In this way a direction can also be found through which transformation can develop spontaneously. Sometimes working also at a physical level may help the therapeutic process to proceed in this direction.

This process is evident in those patients in whom there was a shift from regret to forgiveness or from recrimination to responsibility (see pg 92 H1, and pg. 79 B2).

### **Integration of the five levels.**

The other data that have emerged from the analysis of the experience of Transe is that during the practices, following the psychotherapist's suggestions, subjects are able to integrate the physical level not only with the emotional but also with the mental ones (see examples at pg. 73 H1IX, B4IIIa,b,c, H1XIV, H1XI; pg76 B4X, B1I, B4III).

This can be considered in parallel with the phenomena described in literature as interoception and embodiment. Interoception involves the processing of



sensory input coming from inside the body (Price 2012). This is considered fundamental in mindful awareness of inner experience (Craig 2002). Another common term is embodiment, referring to the experience of conscious connection to the body, involving a sense of identity, which emerges from inner connection (Csodas 1994).

Again, I would like to discuss it with evidences coming from neuroscience studies. In fact, the connection between emotions and sensory-motor apparatus is receiving an increasing attention by neuroscientists. There are many empirical studies exploring the connection between emotion and body sensation. This correlation can be found at many physical levels: skeletal-muscular, neuroendocrine and autonomous nervous system (Levenson 2003). In a recent study published on PNAS (Nummenmaa 2014) emotional feelings were associated with bodily sensation in a culturally universal categorical somatotopic map. For example, anger and happiness would be associated with sensation in the upper limb, according to their approach-oriented characteristics; disgust would elicit sensation in the throat and digestive system. The activation of primary somatosensory cortices during emotional perception and emotional contagion (Nummenmaa 2008, 2012) would favor the hypothesis that emotional perception could involve automatic activation of the sensory motor representation.

This evidence should allow considering Lowen's theory of bioenergetics in a different way. When he affirms that "it is possible to determine the type of character of a person by studying his/her behavior or by analyzing the body's attitudes revealed in form and movement" (Lowen 1985 page 117), there are both psychological and neurophysiologic basis to support this statement. Functional magnetic resonance imaging (f-MRI) studies showed that during emotional processing tasks there is an activation of the inferior and superior parietal medial cortex involved in interoceptive and muscle-skeletal processing respectively (Immordino- Yang 2009). Berkovich (2013) showed also theta activity during altered experience of time in areas involved in somatic information processing and supplementary motor areas. Whereas, altered experience of space is associated with theta activity in interoceptive processing

areas (Berkovich 2013). Moreover, there is also evidence of the involvement of the insular and prefrontal cortex for perceptual motor awareness, suggesting that mindfulness meditation may influence perceptual motor integration process and self-agency (Naranjo 2012).

In BTE the physical level can be integrated with the other three in a whole sense of awareness, through a progressive awareness that passes through listening to both physical and energetic feelings.

Being in a non-ordinary state of consciousness, aware of the mental and emotional contents, and of the physical perceptions at the same time, would favor a process of integration, between these levels, as the examples at pg. 73 and following pages show.

It is interesting to note that this integration is described as an effect of the psychotherapy also at three and six months (see pg. 90 B3a, E2). This data can be considered, again, from the functional and structural changes observed in the brain as an effect of meditation practices.

From a developmental perspective this integration is naturally present at birth. A newborn expresses him/herself with his/her body as a whole. It is quite typical for infants and small children to react to disappointment not only screaming but also stamping their feet and shaking their head. When the cognitive functions start to develop, and influences from the outside world, with moral censures and prohibitions, start to create inhibitions, the so called character armor is developed, acting also on a physical level, stiffening psycho-corporal expression. Therefore the body will only be able to express itself through pain and symptoms of illness.

During the practices patients were invited to give attention to their body and the physical perception associated with the different stressful emotions and thoughts. They could quite often recognize different degree of stiffness or even pain, usually located in the upper trunk region, shoulders and cervical spine, or irritability in the legs; very often there were also visceral perception in the stomach and in the gut. It was like if, being expressed also at the physical level, the emotions or the thoughts were more easily identified and recognized. Going through these physical perceptions was not only important to enter

more in contact with them, but it was also determinant to give them voice, so that the patient was then able to express them verbally and through emotional reaction (crying and screaming). The lived experience of those emotions and thoughts had place at all levels. Again the physical and energetic levels were important to help the subject recognize and be aware of what was happening during the therapeutic process.

Sometimes there was also access to a spiritual level, as the patients would report experiences of light, enlarging boundaries, expansion of self consciousness, inner peace (see pg. 81 B2III, B2V, B3V). In this way it was possible for the subject to integrate the spiritual dimension, recognizing that this dimension is as important as the others.

Similarly to what has been said for dis-identification, also integration is not just a therapeutic tool, but is the therapeutic process itself.

In fact, in agreement with the theories of Bioenergetics, BTE believes that the three levels (physical, emotional and mental) are interconnected. When the energy is free to flow the subject is in a condition of balanced Transe, and the various levels can express as a whole. The awareness of the wholeness might be lost in a condition of chronic Transe as a consequence of blocks in the flow of energy, caused by a many different biographical events (Lattuada 2009). Therefore, restoring such integration means to bring the patient back to a state of harmonic Transe.

Summarizing, from the data collected in this study it has been possible to define the conceptual boundaries of BTE, based on a clinical evidences. As mentioned in the introduction, in order to fully comprehend the BTE concept of cure, we must start from a vision that identifies symptoms as an expression of a block in the flow of energy. From this perspective, symptoms are not to be fought; instead they must be considered as “allies” because they indicate the road to follow to restore the energy flow. Therefore, aim of the therapeutic process is not to fight a disease and to make symptoms disappear, rather to dissolve a block in order to reach again a situation in which the energy is free to flow and the subject can find him/herself again in a state of

“isomorphism of wellbeing”. Hence, the first step is to identify the block. As blocks may express on one or more levels (physical, emotional, energetic and mental), it’s necessary to improve client’s awareness, restoring the integration between these levels.

From the descriptions provided by the clients, what BTE calls a block in the flow of energy, was perceived either on a physical level as tension or pain, or as uncomfortable affective reactions, such as anger or fear. The various BTE practices helped the clients to integrate the different levels improving awareness, so that it was possible to recognize the block in whatever personal stressful life events he/she was dealing with. At the end these events could be faced with a different attitude or from a different perspective.

### **6.3 BTE structural description: the therapeutic setting in transpersonal psychotherapy**

From the therapists’ description of the Transe, I will try to describe BTE structural boundaries, comparing BTE with other psychotherapy models.

From a practical point of view, the psychotherapeutic sessions took place first with an exposition of a problem by the client, followed by the psychotherapist’s invitation to use one of the mindfulness or psycho-corporal practices. To introduce the field these were, usually, the 4 recognitions or MU. Sometimes those practices were enough to provoke an effect on the client’s experience and so the psychotherapist had no need to introduce other practices. In other cases the psychotherapist proceeded using one of the so-called awareness keys, usually the passage from 0 and the captation.

Generally, more than half of the time of a session was occupied by BTE practices. At the end of the therapeutic process a brief phase for feedback took place. During this phase the psychotherapist made sure that the client returned to an ordinary state of consciousness and was able to leave the session safely. Regarding the setting, in some cases the psychotherapist made the client lie down on a couch, while s/he seated by his/her side or behind him/her at head

level. In other cases they both sat down in a relaxed position. In either case the psychotherapist invited the client to close his/her eyes in order to favor inner listening; in some cases even the psychotherapist would close his/her eyes at times. When psycho-corporal practices were used, the psychotherapist performed them with the client, to show the movements and at the same time to share with him/her the therapeutic field.

I already spoke about the use of non-ordinary state of consciousness in a psychotherapy session; here I will consider other two aspects that characterize BTE setting as a transpersonal approach: therapeutic relationship and psycho-corporal work.

### **Therapeutic relationship**

In general the therapeutic process in psychotherapy is based on the relationship between the client and the psychotherapist. This relationship plays a different role in the various models (Cionini 2009).

In psychodynamics, the first psychotherapeutic model, the psychotherapist-client relation was supposed to favor the analysis and elaboration of conflicts. Therefore, the psychotherapist was supposed to stay in a neutral position to help the client to focalize on him/her different projections, as this was necessary for the therapeutic process. During the session the psychotherapist would adopt a floating attention to what is happening to the client.

The cognitive-behavioral approach, coming from behaviorism science would pay more attention to the technical aspects used to favor the change in behavior, emotional reaction or cognitive process (Cionini 2009). In the beginning the psychotherapist-client relationship was not considered significant in the therapeutic process, mainly based on the behavioral theories on learning and cognitive elaborations. Later on, in the seventies, the therapeutic relationship started to be considered as a valid tool for the client to learn how to have effective relationships, and in the nineties the psychotherapist-client relationship was considered determinant for the therapeutic effect, and the term *therapeutic alliance*, was introduced also for this approach (Cionini 2009).

For the humanistic psychotherapeutic approach, the therapeutic process is considered from the perspective of self-evolution, the psychotherapist's role is therefore very important to facilitate the evolutionary journey and to accompany the client in this process. Many factors have been advocated to create an effective relational bond between the psychotherapist and the clients. Buber (1957) said that the I-Thou relationship would involve "presence", commitment to dialogue and non-exploitation. Rogers (1957) indicated empathy, positive regard and congruence.

This position is also valid for Gestalt psychotherapy, for which building a solid therapeutic alliance is essential for the therapeutic process, based on the co-construction of a therapeutic relationship (Cionini 2009).

However, there are other approaches that consider the therapeutic relationship as central in the therapeutic process. From collaborative alliance in the cognitive constructivist therapy, to the client centered therapy and transactional analysis, all of them pay great attention to the psychotherapist-client relationship, considered the actual effective tool to favor the change. In others, such as the systemic relational therapy, the psychotherapist has a crucial role becoming part of the family, triggering a change in the familial scheme. In BTE, considering the therapeutic process as an evolutionary journey, the psychotherapist's role is to accompany the client through this journey. Moreover, as the therapeutic process occurs within a non-ordinary field of consciousness, the psychotherapist will be indwelled in this field with the client. An expanded transference field is created, in which not only the psychotherapist and client's autobiographical experience is included, but also the other levels of the self, with a special reference to the spiritual level and to archetypal contents.

We have seen how the psychotherapist described a deep involvement in the patient's therapeutic process, not just on a mental level but also on the emotional and physical levels (see pg. 71) . It is important to underline that the psychotherapist was always aware of his/her position, and it was able to lead the patient in the process in a supportive way, being respectful of the patient's needs and resistances.

When during the sessions the psychotherapist intervenes by verbalizing his/her experience, this always occurs with the premise that it's what the psychotherapist experiences in the common field. The contents that emerge in this field, be they from the psychotherapist or the client, aren't analyzed nor interpreted, they are only observed with a dis-identification and integration attitude in order to allow transformation to occur.

It is important here to emphasize that the psychotherapist's role, as it has been just described, requires that the psychotherapist is able to understand and acknowledge his/her own internal psychological mechanism, and is constantly aware of them and of his/her state of consciousness. The psychotherapists were always aware of their position, and were able to conduct the process in a supportive way, being respectful of the patients' needs and resistances (see the example of TR H described at pg. 68 and following). This level of involvement imposes a long and laborious training and continuing supervision.

At this point I'd like to recall in this discussion BTE's shamanic roots.

In fact these requirements might be considered, from an anthropological perspective, with some analogies with shamanic culture. In fact a shaman has to go through a process of death and rebirth to gain access to his/her healing power. As mentioned in the introduction, BTE refers to the shamanic tradition sharing its vision according to which the psychotherapist is a medium between a transcendental dimension and the perceivable level.

In a psychotherapeutic model, which is applied in a medical scientific context, this vision results in the psychotherapist assuming a role of facilitator of a healing process in which the client him/herself is responsible for his/her own healing, connecting with the spiritual level. In fact, unlike shamanic traditions, for BTE everybody can access a transcendental level through practices that are usually called meditative.

This role demands that the psychotherapist him/herself has fulfilled an evolutionary process that led him/her to master non-ordinary states of consciousness, and to let his/her personal history go. This process must not be seen only from the academic and educational point of view. Rather, it is similar to a spiritual evolution process, because only experiencing in first person these

non-ordinary states of consciousness it is possible to master them and share the healing field with the clients. If the therapeutic process is a journey towards inner transformation, in order to be a valid helper the psychotherapist must have already accomplished the same process.

### **The psycho-corporal dimension in the therapeutic process**

Another characteristic aspect of BTE is the attention to the psycho-corporal dimension.

In BTE the body is considered from a holistic perspective. The physical level is interconnected with the other levels, (the energetic, the emotional, the mental and the spiritual ones). Therefore, working on each one of them means to affect also the others. For this reason during the psychotherapeutic process the attention to the physical level is often solicited. Even more, the body can be directly involved through movements and or touches.

Movements are performed in a non-ordinary state of consciousness, keeping the attention to the other levels.

In this study often movements were used to help the patient to become aware of the physical aspects. During the movements the psychotherapist would solicit the patients to focus his/her attention also to the other levels so that integration could occur.

Sometimes psychotherapists used movements to help the patient to connect with archetypal qualities. For example to favor the self-awareness of self power and personal strength through the metaphor of fire and metal; or to help the patient to let go past events, and their burden of sufferance, with the metaphor of water. The movement would favor the embodiment of the quality elicited by the metaphor. In this way is possible to work not only on the mental level, but also on the emotional and the physical ones.

As described in chapter 2 (page 32) Lattuada speaks about the integration of Mudra, Mantra and Yantra, referring to the Indian culture, to explain how the spiritual dimension can affect the different levels of experience. During the practices the clients reported such integration to occur, either spontaneously or after solicitation by the psychotherapist. This integration would favor the



awareness of the different levels and how each one of them would affect the others.

Moreover, BTE in addition to movements introduces also touches in the psychotherapeutic process. Touches can be used to focus attention on some physical sensations, for example if the client reports a feeling of weight in the stomach the psychotherapist can lay a hand at the level of the stomach.

Touches as massage were not used by the psychotherapists participating to this study. The only kind of contact reported was when the psychotherapist put his/her hand on the part where the patient was reporting a pain or some kind of disturb, usually the stomach or the head. This contact would help both of them to feel the shared field and favor the therapeutic process.

Even considering all the cultural and ethical-legal aspects of this topic, some clinical experiences, describe how in some cases physical contact is very important in the therapeutic process (Leijssenn 2006). Obviously the openness to physical contact must be verified in a preliminary phase, specifying that in any case, no form of sexual contact will take place. Violent acts are also banished.

The involvement of the physical level is a quite peculiar characteristic in BTE; I would like to consider this topic in contrast with other psychotherapy approaches.

Just to start from the beginning, considering the first psychotherapy model, Freud developed psychoanalysis as a therapy for somatic disturbances. He tried to understand the psychic disturbances that were causing the somatic symptoms of hysteria. However in the therapeutic process the body was not considered at all. The client would lay down concentrating only on the mental dimension. Freud would acknowledge the physical property of the Ego, but the psychotherapeutic process was concentrated on the other non-physical components (Cionini 2009).

In the following evolution of psychotherapy the body was again considered in the psychotherapeutic process.

Ferenczy (Messer 2003) tried to integrate the analytical procedure with practices that would involve the body. Reich (1942) introduced the concept of

energy in physical terms and Lowen (2009) described how the body and the psyche interact and he actively involved the body in the therapeutic process. Similarly Fritz Pearls (1997) was against the dualism, described by Freud, between the physical Ego, with conscious material, and the unconscious with no physical dimension. The core of Gestalt theory that the totality including the parts is bigger than the sum of the parts, would applied also to the human system. Therefore it is not possible to consider the psyche and the body separately.

Both the Gestalt and Bioenergetic would actively use the body in the therapeutic process, as a medium to facilitate the expression of psychic elements.

In general, two modalities to consider the body in the therapeutic process can be described. *Internal techniques*, in which the focus is on the affective process already present, and *external techniques* in which the movement is designed to stimulate an affective process, not yet conscious (Leijssenn 2006). In both cases, movements can be understood as an expression of emotional contents, gestures can be emphasized in order to stimulate a greater awareness of emotional contents through a greater activation of the proprioceptive system. F. Pearl used awareness of body structure to develop dramatic life scenes (Bingham & Hull 1997).

There are also other psychotherapy approaches in which attention is given to the body. For example in focusing oriented therapy (Gendlin 1996) the attention is directed to what the body experiences in relation to visceral processes and emotional experiences. Of course part of the attention is still dedicated to verbal communication, especially if it comes from emotional reaction. The psychotherapist can also verbalize his/her feelings during the process; in this regard Greenberg and Rushanski-Rosenberg (2002) speak about 'somatic counter-transference'.

This is the same theoretical framework for BTE. Similarly to Gestalt and Bioenergetic the body is considered from a holistic perspective, integrating the physical level with the mental and emotional ones as part of the totality. However, in BTE there is also a transcendental dimension to be included in

the totality. Even the energy coming from the natural elements would interact with the body and express at a psychic level. At the same time individual's spiritual dimension can express also through the body and can influence the body.

In this regard BTE might look similar to Reich's approach, as he also considered that touching the client would help to break the armor (Reich1973). However, in BTE the approach is softer as the armor is considered part of the Self that needs to be acknowledged and integrated in the process of dis-solving (Lattuada 1997).

Touches can also be applied in form of massage in order to facilitate contact with an archetypical quality, as described in the introduction.

For BTE working with the body means working also with the other levels, as all levels are interconnected. Furthermore, psycho-corporal practices are always performed as a form of meditation, meaning that they occur always in a non-ordinary state of consciousness, which allows the understanding of how the different levels interact. For example, the backache verbalized by a client during a practice isn't just an expression of pain or muscular contraction, but it might tell us about the client's anger and his/her difficulty to accept it.

Before ending this presentation about BTE's conceptual and structural boundaries, I'd like to summarize briefly the analogies and differences between BTE Gestalt and Bioenergetics, the two approaches in which Lattuada was trained and that contributed to the elaboration of BTE model.

All three approaches share an existential perspective of the individual, meaning that they consider the totality of his/her existence. As well as Gestalt and Bioenergetics, BTE focus the attention on the integration of mental and emotional experiences on the physical and energetic levels. BTE though goes even further considering also the spiritual aspect.

All three share an experiential approach, meaning that they stimulate the experience of the emotional contents, rather than their interpretation. Even in the feedback at the end of the session there was not an interpretation or explanation. The attention is focused on "*how*" not on "*why*". In this regard BTE can be considered among those approaches described as

phenomenological. Moreover for BTE it is important to work in a non-ordinary state of consciousness for the therapeutic process to develop. In all three approaches the therapy develops in a “here and now” dimension. Everything regarding past events is considered in the light of what it means now for the client. Not to interpret it on a cognitive level, but in order to identify in which level the event is acting and so find the correct action in order to transform the block created by that specific event.

### **Concluding summary**

In conclusion, conceptual and structural boundaries based on this clinical study, conducted by 7 psychotherapist and 13 clients, with a total of 121 clinical session examined, can be described.

The study was focused on the psychotherapist and the clients’ description of the Transe process during the psychotherapy session. Aim of the study was to understand how the Transe works to the therapeutic effect and self-development.

From the conceptual perspective, the Transe, that is the field of non-ordinary state of consciousness, allows the integration of the five levels, physical, emotional, mental, energetic and spiritual, to occur. At the same time a process of dis-identification from the mental and emotional contents might happen. These two effects allow the therapeutic process to develop through two different ways: either the so called primary cycle of observation-acceptance-awareness or the secondary cycle of contact-mobilization-direction-transformation.

This therapeutic process would lead to a subjective state of well being, improving awareness about both the physical level and the psychological dimension. As far as the latter is concerned, clients reported greater awareness of their inner mechanisms, both on the mental and the emotional levels. It was also reported an improving of self listening and also listening to others’ emotion, leading to more satisfying relationships.

As far as the structural boundaries are concerned, the psychotherapeutic relationship in BTE is based mainly on observation and listening by the

psychotherapist, which shares with the client the therapeutic field, completely, even at a physical level. No interpretation or cognitive elaboration of the mental and emotional contents have place during the therapeutic session. The body plays an important role in the therapeutic process. In fact, through the body the other levels can express or can be explored. This can happen either by observation and listening or by movement and touches.

#### **6.4 Heuristic method for clinical studies in transpersonal psychotherapy**

The last topic of discussion will be about the research method applied in this clinical study.

As I already said, the main field of interest of transpersonal psychology is the inner perception of conscious experiences.

Some psychologists are still skeptical, if not even hostile, toward transpersonal psychology. For example Schneider (1987) would criticize the transpersonal concept of “*ultimate consciousness*”. Even if, as discussed by Koltko (1989) there is a misunderstanding as the concept of transpersonal consciousness is different from the concept of “ultimate”, still must be recognized that until a few years ago, transpersonal experiences were based only on a few description of personal experiences.

However, the cultural panorama has been changing in more recent years. On one side there is a growing interest, especially from cognitive science, about spirituality and meditation practices. On the other transpersonal psychologists are progressively engaging more in clinical research.

As Walach (2013, page 73) pointed out: “Transpersonal psychology has simply assumed that inner experiences have some epistemological validity, without any understanding of the extremely difficult ontological ground upon which it is marching”. He proposes to solve the ontological problem of consciousness appealing to the quantum physics. Even if he recognizes that quantum properties pertain only to quantum system as such, still he uses the same conceptual structures and framework. However this approach does not help transpersonal psychology to develop into clinical practice based on evidences.

To this aim a different approach to research is necessary.

Other transpersonal psychologists took a different direction. For example Braud (1998) suggested that transpersonal experiences might be explored from four different perspectives:

- a) Nature of the experience itself.
- b) How might the experience be conceptualized
- c) How does the experience unfold and develop
- d) What are the outcomes of the experience?

This framework follows the line of scientific research having specific and different aims: describe, explain, predict and control the topic under investigation. Therefore, depending on the area of interest different research methods might be used. Quantitative methods for explaining and comparing, as they are said nomothetic, meaning that they try to produce general laws, universally true. Whereas, qualitative methods can be used for describing and understanding, as they are said idiographic, trying to capture the uniqueness and the complexity of a phenomenon.

More complex design might require a mixed method as described by Creswell and Plano (2011):

- 1) Convergent design: qualitative and quantitative methods used in various combination in the same study
- 2) Sequential design: a qualitative study is followed by a quantitative study
- 3) Embedded design: some quantitative data are collected within a qualitative study
- 4) Multiphase design: multiple studies, including qualitative, quantitative and mixed-method design are conducted over a period of time, linked by a common purpose.

Both quantitative and qualitative methods have been specially developed for transpersonal research. Quantitative methods include well-established psychometric assessments, as reviewed by McDonald, Friedman et al (1999). As described by Anderson (2013) qualitative methods for transpersonal research are:

- 1) Intuitive inquiry, influenced by embodied phenomenology,

hermeneutic and heuristic, affirms intuition, compassion and service as central to research and to understanding anything important about life.

- 2) Integral inquiry, whose essential feature is to be inclusive, pluralist, programmatic, radically empirical and flexible.
- 3) Organic inquiry, in which the psyche of the researcher becomes the subject of the research. The term organic refers to the process of transformation associated with the research process, conceived to be a living and mutable process.

When I came up with my research question for the present study, as I was interested in understanding the nature of an inner experience, describing it from a subjective point of view, I knew I had to use a qualitative methods. The only problem would have been that I was considering a particular setting, with many psychotherapist participating as co-researcher, each one with his/her clients, in what in the medical field would be called a multicentre study. In fact, I intended to base the present study not just on my personal experience, or on a single case study, rather I was interested to explore in general the experience of psychotherapists and clients.

None of the transpersonal method I summarized earlier would fit this specific research question, therefore I decided to stay with a qualitative method, which would acknowledge the inner perspective of the researcher, but leaving more freedom in collecting the data from different subjects.

I considered the possibility of combining the phenomenological approach with the heuristic, as suggested by Finlay (2009). However, the need of the bracketing process inherent phenomenological approach and the requirement of objective description of what emerges from the descriptions, led me to consider the heuristic approach completely, adapting the method for the setting.

Based on these considerations, I developed the study according to three heuristic concentric levels, to include all the different subjects of the study.

The first level corresponds to the field created between the psychotherapist and the client during the session, which I have fully illustrated and discussed in the results about the Trance. This common field, in fact, presents all the

characteristics of the heuristic knowledge described by Douglas and Moustakas (1985), reaching almost what is described as embodied knowledge. This is even truer if we consider the self-evolution perspective of transpersonal psychotherapy.

In this study, some of the clients chose a transpersonal approach as they had a special request of self-development. This evolution develops through a process of self-knowledge, not only of the psychological mechanisms put in place in different situations or cognitive processes, but also expanding the boundaries of consciousness through the practice of meditation to connect with the subtler planes and with a spiritual level. It is exactly this kind of knowledge that occurs with heuristic method. Therefore, we can say that the heuristic method is already in place during the psychotherapeutic session in the field that is created between the psychotherapist and the client.

In this study, the second level of the heuristic process included me as principal investigator and the psychotherapists as co-researchers. In this case, the field was created during a series of meetings, partly collective and partly individually. During the meetings the study was explored as a process of knowledge. Since both I and the co-researchers were trained at the same BTE School, the practices and their lived experiences, which are the subject of the study, are part of a common cultural background.

A first collective meeting was held to create the field in which we were all immersed. The interest to the research question was shared among all, and the most committed (seven out of ten) completed the study. Then, some individual meetings, on a monthly base, in person or on Skype, had place. Before the meeting the co-researchers had sent the material so that I could see it in advance and we could discuss it during the meeting. We discussed both some technical aspects, generally the adequacy of the material collected in terms of the richness of content, and the experience of the TR about his/her feeling about the participation in the research.

The third level, which encompasses the other two, includes me as principal investigator, the psychotherapist as co-researchers and the clients. This is the field that I have explored during data analysis. The manner in which the



psychotherapist collected the information from the clients gave them a feeling of sharing a larger field, as two of them said, and introduced my presence in the therapeutic field as a third one testified with her greetings (Figure 1 Appendix 3b pg 175).

From this perspective I must say that perhaps the clients should have been considered as co-researchers, making it even more obvious the process of heuristic search.

Moreover, both the psychotherapists and the clients reported the feeling as I was present during the session, confirming that the phenomenological approach was not the correct approach. In fact, a phenomenology method would have required the researcher to step back, as an external observer.

As far as I was concerned, during the analysis phase I found it very engaging and emotionally challenging, to read the stories of clients, and transcripts of some sessions. Entering into a field so personal and intimate might bear the risk of looking like a voyeur, but I have always maintained a respectful attitude toward the participants in the study, and adopted the practices of meditation described above, first of all transition from 0, to allow myself to always keep a clean look, so to speak. The motivation for this research has certainly helped giving me all the support and commitment required. Moreover, these practices helped me to go through the explication phase using second attention.

Speaking of commitment, this method of investigation was definitely very challenging, as described by all the TR, including those who have dropped out for this reason.

I would like to point out in this regard that the commitment is not to be referred to the particular research design. In fact, from my past experience as a psychiatrist, I have participated in numerous clinical pharmacological trials and even in those cases the effort required for data collection, albeit in the form of quantitative psychometric scales, was remarkable. It must also be mentioned that pharmaceutical companies often provide some sort of compensation for the researchers involved in the study, in order to favor their commitment.

In conclusion I can say that the heuristic method used in this study allowed us to investigate the phenomenon of Trance, describing its meaning from the

point of view of the client and the psychotherapist. The design of the three levels has allowed us to effectively conduct the study in a clinical setting.

I would like to conclude this discussion about the heuristic method, with some remarks about possible bias of the method its-self.

One of the requirements of heuristic research is the research involvement into the phenomenon. This can be a bias when it comes to generalizability of the interpretation. In this case however, the subject which did the analysis was not the same who collected the data, but at the same time was close enough to the phenomenon to be still acceptable for the heuristic method. To further improve the validity of the interpretation I did not limit myself to the feedback from the psychotherapists co-researchers, but I considered also a critical friend, expert in BTE and in other psychotherapy approaches, mainly Gestalt. I used these descriptions to define conceptual and structural boundaries. These boundaries seem to fit well the theoretical model elaborated by Lattuada, based also on his personal clinical practice. These data are based on a large number of clinical sessions, with many different psychotherapists and patients. The heuristic model, adapted for the present clinical study, proved to be well suited for the purpose, providing a tool to go beyond personal clinical experience or single case study.

Some interesting hypothesis originated from the comparison of the data described in this study with data found in literature. This hypothesis about changes in brain function and structure associated with meditation practices would disclose new areas of research to be carried out using other research tools (mainly brain imaging techniques).

## **6.5 Critical points**

To conclude this discussion I would like to consider some critical points. First I will consider the study in general, with particular reference to possible bias, inherent the heuristic approach. Then I will consider some critical points about BTE emerged from data analysis

## Study

The first point to be considered is about the psychotherapists' role as co-researchers. Even if the study was focused at the description of the Transe in a therapeutic setting, not aiming to prove efficacy of the BTE method, a possible pitfall may come from the desire of the co-researchers to appear in a positive light. To avoid in part this possibility their participation was kept anonymous, and Lattuada, with whom some of them are still in contact, was not involved in the study at any time.

Still it is possible that someone might argue that those sessions, where the therapeutic process did not evolve in a "positive" way, meaning that a transformative process had not place, might have been omitted.

However, I must say that not all the data collected were coming from "positive" session, as sometimes the patients would not describe any transformation during the practice, or would even report some negative feelings (see for example page 83 B4II or the example of patient H1 described at page 69 and following). Of course, these sessions were considered anyway and actually they provided some insights about BTE. In fact I could see that most of the time the patients reported negative feelings when during the therapeutic session he/she was not able to integrate the different levels, staying mainly in a mental level. This lack of integration might have happened for different reasons, coming either from the patient or from the psychotherapist or, most likely, from both. However, even if it could provide interesting data about BTE structural boundaries, the analysis of these factors was not part of this study.

Another bias may come from the heuristic method used for the study.

Like all qualitative approaches, heuristic method requires also a deep involvement of the researcher in the phenomenon under investigation.

Of course this could be a bias if we consider generalizability.

However this study was really focused on BTE methodology, aiming to describe the Transe as a non-ordinary state of consciousness.

At last, but not the least I considered also my involvement with the Transpersonal School, conducted by Lattuada. However, being aware of this

possible bias, and most of all considering my professional development as a researcher in the field of brain imaging, which I reported in chapter 1, I feel that I could keep a critical mind not to accept a priori some theoretical statement. As a matter of fact I could also find some critical points about BTE model as I will discuss further on.

In this process of critical evaluation of BTE conceptual and structural boundaries was really helpful the academic consultant, Eleonora Prazzoli, a clinical psychologist trained in gestalt and BTE.

### **Working with non-ordinary state of consciousness**

One of the most important critical point is about the resistance of some patients to work in a therapeutic setting using non-ordinary state of consciousness.

In fact many times (approximately 30% of the total session submitted), the co-researchers reported that the patient wanted to stay more at a “talking” level.

In some cases this was due to a specific request by the patient, which had some kind of resistance to work in a non-ordinary state of consciousness. Other times was the psychotherapist to decide not to use non-ordinary state of consciousness feeling that it would have been better for the patient. Of course also in these cases a Transe, that is a shared field of consciousness, was created between the psychotherapist and the patient, even if in an ordinary state of consciousness, in which BTE psychodynamic could be followed to favor a therapeutic process.

However I think that the difficulty to work with non-ordinary state of consciousness is a very crucial point not only for BTE, but for transpersonal psychotherapy approaches in general.

Again there can be two possible explanations for this: one is about the patient and the other about the psychotherapist.

As far as the patients are concerned from my personal experience, I can say that there might be more difficulties when the patient did not choose BTE especially because of the transpersonal approach. This might happen with patients referring to a National Mental Health Structure. Considering the

patients participating to this study it was more frequent for those patients that were not used to meditation or similar practices.

As far as the psychotherapists are concerned I can see two possible factors.

The first one regards those psychotherapists specialized in other approaches, namely psychodynamic and psychosynthesis, were more prone to use also the other approach. Quite often was the patient that would ask for the other setting in which he/she would feel “*more comfortable*”.

The second one is about the experience to work with non-ordinary state of consciousness in a therapeutic setting. As I already said, speaking about the psychotherapeutic relationship at pg 118, working with non-ordinary state of consciousness requires a long and extensive training. The two co-researchers reporting more frequently the use of different setting were the youngest in terms of year of practice, even if they met the requirements to participate to the study. So it might be possible that this was the reason to be more prone to avoid working with non-ordinary state of consciousness.

It is interesting to note that all the co-researchers, found that the heuristic process of collecting and discussing the data for the present study, helped them to reflect more on the therapeutic process in which they were involved with the patients. They all reported that it was almost as a supervision session.

### **Awareness Keys**

Another critical point is about the so called awareness keys.

The term “awareness keys” is used by Lattuada to indicate both a mindful practice during the therapeutic session and the therapeutic process. This double aspect can be easily understood considering what I said about mindfulness as a therapeutic process and not as a therapeutic tool in transpersonal psychotherapy.

Lattuada speaks about seven awareness keys, as I described in chapter 2 (see page 34).

As I already said, the co-researchers used a variety of names to identify the different practices and did not clearly indicate the awareness key through which the therapeutic process developed. Usually they would use the 4

*recognition* and *MU* to introduce the field. Then they will proceed exploring the Transe using a psycho-corporal practice or a mindful practice defined as passage from 0 or captation (see page 31).

When using the passage from 0 the psychotherapist used to intervene very little, usually through metaphor of being at the source. During captation the psychotherapist would intervene more, helping the subject to give voice, or giving voice him/herself directly, to whatever was raising in the field. What I found critical from this perspective is that the psychotherapists would not refer to the awareness key, or they will do it in a different way from one another.

It seems that during BTE mindfulness practice one or the other awareness key had place, in some way or the other. For example patients were sometimes able to “recognize misleading reality based on judgment and identification”, to use Lattuda’s words to describe the “organismic Transe”, however this can be described more properly through the dis-identification from emotional content and cathartic reaction than transcending boundaries of ordinary mind.

Similarly, other keys, like the mastery of Transe, the practice to give voice to the block of energy and favor the secondary cycle was described in some sessions. However, the description given from Lattuada does not provide any information on how the process has place, whereas from the description given by the psychotherapists and the clients and discussed in this study seems more linked to evidence.

At the same way the key “freedom from the known” speaks about dis-identification and this is one of the most important aspect of the therapeutic process. But again Lattuada’s description is more grounded in philosophical than in practical terms.

When I considered the data for the analysis, I let the themes to emerge from the data, without looking at them with “BTE glasses”. However when I had to consider what emerged, namely dis-identification and integration, the awareness keys did not fit completely. I discussed this point with my academic consultant, and it seems that the incongruence between the theoretical framework and clinical practice comes from a different language as Lattuada seems to speak more in philosophical terms. Also the map provided by the

awareness keys seems too far more complex than reality is. Staying with the metaphor of the map we can say that Lattuada's description is a geographical map, whereas this study provides a street map.

### **Archetypical forces**

A peculiar aspect of BTE is the importance given to the archetypical dimension, represented by elemental forces of nature. This is the aspect that characterizes BTE as a transpersonal psychotherapy. Lattuada considers the importance of the archetypes in their development through the history of philosophy and religion, both in the western and eastern culture, before being introduced in psychology by Jung.

As I described at page 30 BTE refers to the archetypical forces, represented as metaphors of natural forces, which are considered as real and authentic energy expression of a transcendental dimension. In theory going through a therapeutic process in a non-ordinary state of consciousness would favor the contact with this dimension. However, in the sample considered for this study, this happened rarely. When it did happen it was suggested by the psychotherapist as a metaphor to work on some aspects. There was for example the reference to the fire or the metal to suggest strength or to the water to suggest fluidity (see page 85). It never happened that the patient referred to such an archetypical dimension first, even when he/she was deeply indwelt into a process in a non-ordinary state of consciousness.

It is therefore quite disputable that during the therapeutic process it is possible to experience the energy of natural forces in a transcendental dimension. Of course, this can happen with subjects trained in mindfulness practices, or it can be highly dependent from socio-cultural environment. In fact the patient sample considered in this study came from a cultural background not very oriented to favor a knowledge of these phenomena.

As far as this study is concerned it seems that the archetypical level is used mainly by the psychotherapist as a metaphor to favor a process or a perspective to look at some phenomena. Of course some may say that the transcendental dimension influenced the therapeutic field in some way, but of

course this is out of the boundaries of any possible demonstration.

This is quite a critical point for transpersonal research in general, as the transcendental dimension is so crucial for transpersonal psychotherapy but it is really difficult to investigate even with qualitative approaches.

### **Concluding summary**

As far as the heuristic method is concerned I acknowledge that the involvement of the co-researchers and myself is of such great importance that generalizability cannot be considered. What emerged from this study, that is the meaning of the Transe in the therapeutic setting, was used only to define conceptual and structural boundaries of BTE as a transpersonal approach of psychotherapy.

As far as BTE is concerned critical points to be considered are the map of the awareness keys and the role of the archetypical dimension in the therapeutic process.



## **CHAPTER 7 – Research outcomes**

As I discussed previously there were two reasons to undertake this research study. One was to expand the knowledge of transpersonal psychotherapy in general and the BTE model in particular among practitioners in Italy. The other was to stimulate the interest for research in the transpersonal field, both in Italy and among the Eurotas community.

I know that most of the people would think that a book is the best way to disseminate knowledge. However, may be because of my previous research background I am more prone to write articles for scientific journal or give oral presentations at conferences. Therefore when I had to consider the research outcomes of this study I planned to write one or more articles and to organize conferences for clinical psychologists and psychotherapists. Then from my academic consultant, which is involved in the Integral Transpersonal Institute Editions and teaches at Milan University, came the invitation to write a book, and of course, I accepted.

In this chapter I will tell the story of these research outcomes and how they will contribute to fulfill the intent which was at the base of this research study.

### **7.1 Writing a book: “Transe: the healing field”**

When I was discussing about this study with the academic consultant (Eleonora Prazzoli) she asked me: “Did you consider the idea of writing a book on this study?”. As I said a book was not in my plans, however when it came as an invitation I considered it with some pride, of course, along with some concerns about the commitment required. I am used to write articles for scientific journal, and even for electronic journal for a general audience; however, writing a book requires a more profound and articulated discussion. I spoke with her about these concerns and together we discussed how to plan the contents .

The main topic will be the Transe as the healing field.

I will start describing the evolution of the therapeutic setting considering its evolution from sacred space, referring to both the Aesculapius cave in

ancient Greece, considered the origin of western culture, and the sciamanic culture from different countries, to arrive at the actual technoscientific area of knowledge, expression of the modern western medicine. This is a very important topic for me as medical doctor, and of course, in this excursus the particular field of psychotherapy will be considered as well referring to the major psychotherapy approaches. Then I will describe the epistemological and scientific assumptions of Biotransenergetica approach will be discussed, in reference to both the psychodynamic and therapeutic methods, based on non-ordinary state of consciousness will be described. Particular attention will be given to the concept of Transe as it is defined by Lattuada in his books. Finally I will present this study, conducted with the psychotherapist and the clients, to define the Transe as healing field as it emerges from clinical practice.

This book will be published by the Integral Transpersonal Institute Eds. It will serve the students of the BTE School and, as doctor Prazzoli said, it could also be of interest for the students enrolled in the clinical psychology class at the Bicocca Milan University where she teaches. Even if writing a book for the Integral Transpersonal Institute Eds. might seem to play for safety, still I am very concerned about the effort and commitment. I already started to collect the references, even if most of it comes from this dissertation, and started the first draft. I am looking forward to enter into the creative phase of it and see this product as a creature of mine.

## **7.2 BTE presentation in mental health clinic and hospitals.**

To expand the knowledge of transpersonal psychology and psychotherapy in Italy, I think that it is important to reach the clinical psychologists at mental health facilities and even at University.

When almost ten years ago I applied as a resident at the clinical psychology of Garbagnate Milanese Hospital I was easily accepted because the head of the clinic knew me as a medical doctor specialized in psychiatry. She trusted my previous academic education and did not ask too many questions about the specific BTE psychotherapy approach. Similarly during the residency program she kept a critical point of view but was very open to discussion.

However I know from other students that it is very difficult to find clinic that will accept students because of the particular approach. For this reason, I decided to present the results of the study at clinics and institutions where the clinical psychologists and psychotherapists work, in the format of a continuing medical education event. I think that the design of this research as a clinical study will stimulate the interest of such an audience, always concerned about scientific validity.

I thought to start with the public and private institution where students from the school practice as residents. Even if these institutions accepted the students, they do not know much about transpersonal in general and BTE in particular.

One was already held in Garbagnate Milanese, nearby Milan, where I practiced as resident during my training (see Appendix 4b pg 177 and following).

23 participants attended the presentation. Five were clinical psychologists from the psychology service and the rest were residents, from the university and from psychotherapy school with different approaches.

At the end of the presentation a questionnaire was given (Appendix 4c page 180) to collect information about their knowledge of transpersonal psychology and psychotherapy, about BTE and about qualitative studies.

Only three of them knew about transpersonal psychology, 2 because they heard of it at university, and one from other source. Six of them knew about

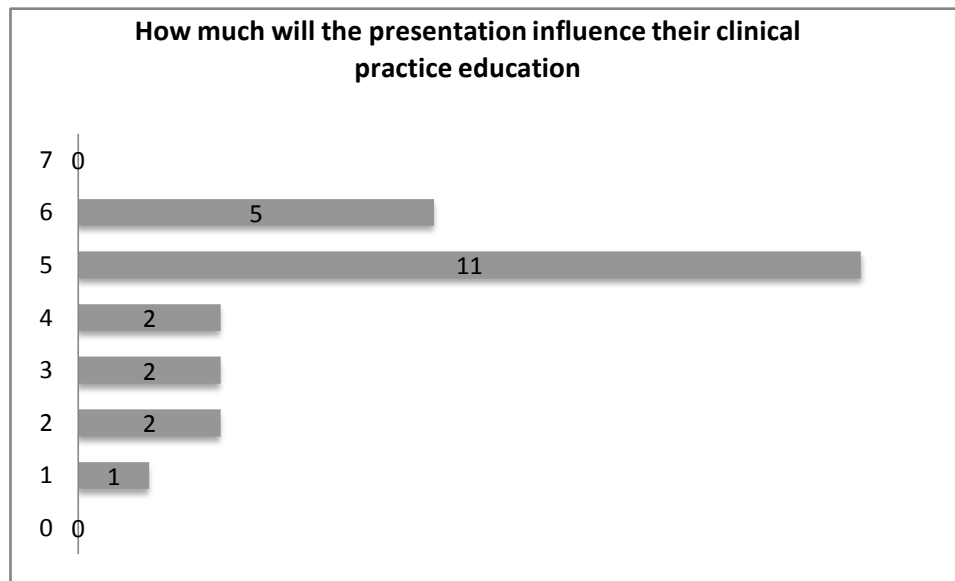
BTE: three because they heard of it at University (one of the teachers of the BTE school is also a teacher at the Psychology School of Bicocca University in Milan), one from the psychotherapy school, and two from other sources. It is interesting to note that these six participants said that they did not know about transpersonal psychology and psychotherapy. I think that this can be interpreted in two ways: they heard about BTE but were not interested to get a deeper knowledge on transpersonal, or did not associate BTE with transpersonal.

All of them knew qualitative approaches to research, having studied this matter at university. However this knowledge was limited to focus group and interviewing.

The graphic below (Figure 3 page 138) shows how participants answered to the question on how much the presentation would influence their clinical practice education. The three who answered 1 or 2 said that they were not in favor of the particular approach used, as they are studying a psychodynamic approach. The two answering 3 said that they did not like the particular research approach used.

In general, I can say that there was an interest to the topic and the majority seemed to be open to learn about this approach and was eager to discuss it. People were particularly interested on possible similarities with other approaches and were curious about the non-ordinary state of consciousness in which the therapy was conducted.

I have already planned other conferences in other clinic and hospital, through which I hope to raise interest about BTE and transpersonal, stimulating the discussion.



**Figure 3:** Participants were invited to evaluate how much the presentation would influence their clinical practice education on a scale from 0 (not at all) to 7 (a lot).

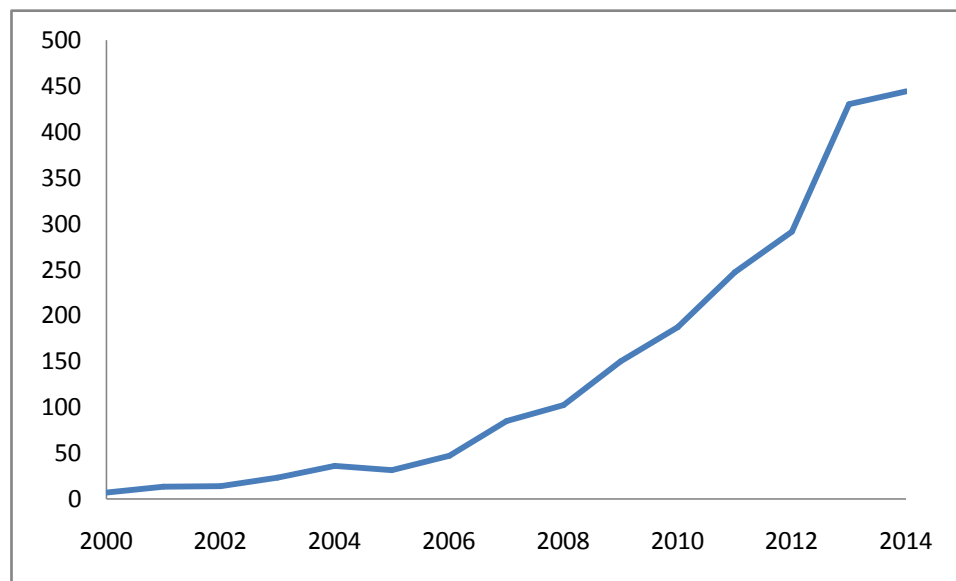
### 7.3 Research practice among transpersonal psychotherapists in Italy and in the Eurotass community.

The second level of my involvement in research in the transpersonal field is to expand the research attitude among transpersonal psychologists, both in Italy and in Europe.

As I already said there is a growing interest on state of consciousness and meditation practices among medical doctors as well as mainstream psychologists.

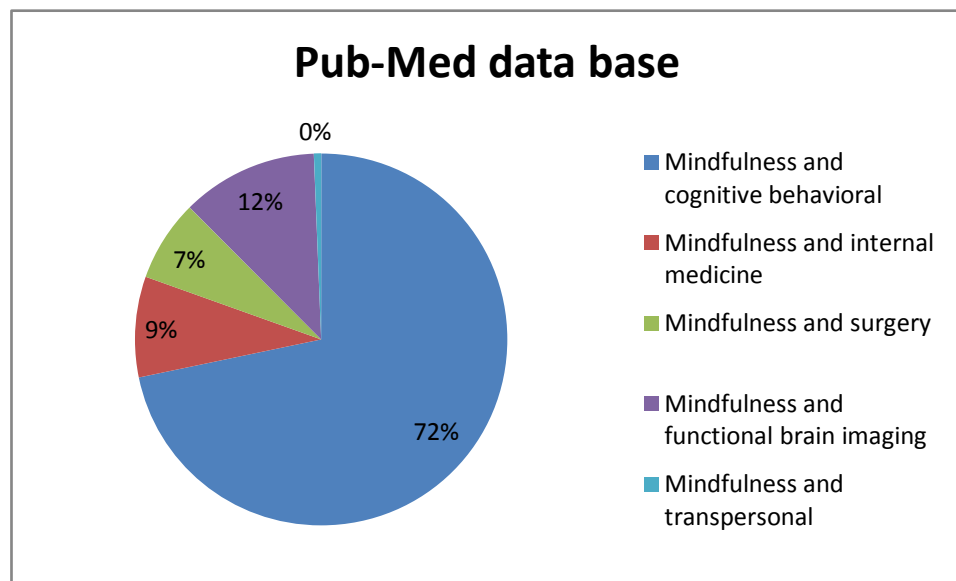
When I analyzed a literature review, on Pub-Med data base, using the words “state of consciousness”, using a time filter, in the time interval from 1990 to 1999 there were 945 papers, from 2000 to 2014 the number was 2509.

Using the word “mindfulness” in the time range 1985-1999 there were only 35 papers. In the time range 2000-2014 there were 1807 papers. In the graphic in figure 4 (page 139) the number of publication per years is shown.

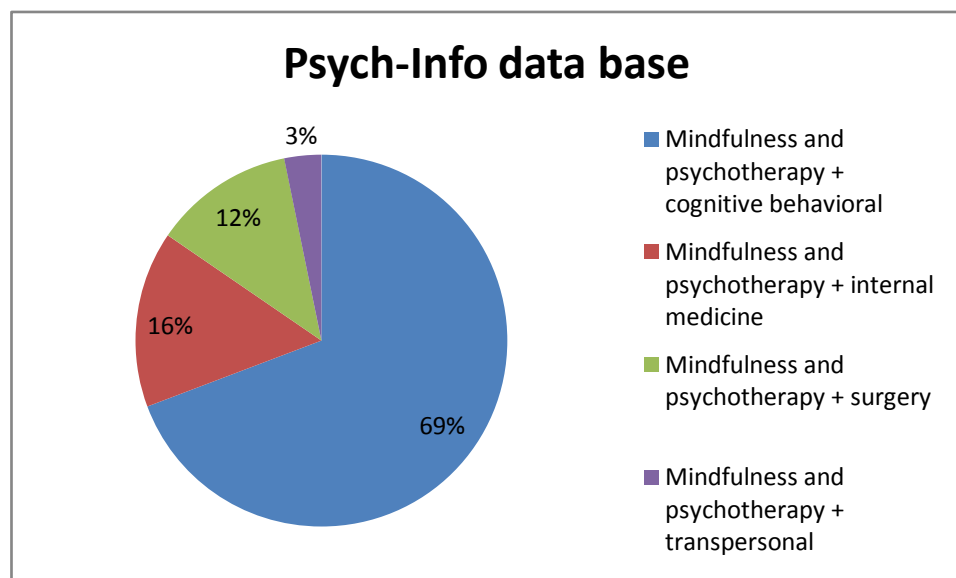


**Figure 4:** this graph shows the number of papers published per year using mindfulness as keyword (Pub-med database).

An increasing interest from the medical field on mindfulness is evident. In the graph in figure 5 (page 140) I show the number of papers combining “mindfulness” with other key-words: cognitive-behavioral, internal medicine, surgery and transpersonal. Of course the most numerous comes from the psychology field, but still there are also papers from the medical field, as mindfulness is used for chronic diseases especially in relation to pain control. What is surprising is that only 3 papers come from the combination of the word “mindfulness” with “transpersonal”. Only one of them was about the transpersonal approach Walach (2005), while the others were only citing transpersonal in the abstract.



**Figure 5:** this graph shows the distribution of the paper using “mindfulness” and other keywords: cognitive-behavioral, internal medicine, surgery and transpersonal (Pub-Med data base).



**Figure 6:** this graph shows the distribution of the paper using “mindfulness and psychotherapy” and other keywords: cognitive-behavioral, internal medicine, surgery and transpersonal (Psych-Info data base)

Using Psych-Info data base, shown in figure 6 (page140) the numbers were of course slightly different. In the time range from 1985 to 1999 using “mindfulness and psychotherapy” as keyword, there were 90 papers from peer reviewed journal; this number rises to 4274 in the time range 2000-2014.

Combining mindfulness with other key-words (cognitive-behavioral, internal medicine, surgery, and transpersonal) the division was quite similar to the data coming from Pub-Med, as the graphic in figure 6 shows.

How is it possible that even if there is an increasing interest in meditation and state of consciousness from the medical field and mainstream psychology, the transpersonal field is so under-represented?

I think that there can be two possible explanations. On one hand there might be a lack of research interest by practitioners in the transpersonal field. I can be quite sure about this at least as far as the Eurotas community, which I know very well, is concerned. On the other hand there might be a lack of scientific approach causing difficulty to reach for publication by indexed journal for transpersonal researchers. In fact there are three journals on transpersonal psychology and psychotherapy: The International Journal of Transpersonal Studies, the Journal of Transpersonal Research and the Integral Transpersonal Journal. Only the first one is indexed in the Psych-Info data base.

I think that this is not only due to ostracism from mainstream psychology. I think that it is important to stimulate research interest and improve research attitude among transpersonal psychologists and psychotherapists.

To work in this direction, as far as Italy is concerned, I already teach science methodology and neuroscience, at the Transpersonal School in Milan. I also tutor some student for their final dissertation helping them to design a research project and carry it out.

I organized workshops with the students to encourage them to consider research as a valuable tool to explore and improve their practice. It has not been easy at the beginning, as they had the preconceived idea that research is just for psychology in the laboratory or for ethnography, they did not know that it could also be applied to clinical practice.



Regarding Europe, I started a project inside the European Transpersonal Association (Eurotas), with other three colleagues. We called it “Eurotas Division of Transpersonal Research” (EDTR).

As a chief editor of the Integral Transpersonal Journal and as board member at the Eurotas association I was surprised to see how very little interest was given to research by the majority of Eurotas members.

Many of them are trying to reach a wider audience, and struggle to get their practice to be recognized by academic and local National Health Institution. However what they do is unsuccessful. I think this is because they miss the strong argument which can come only from research.

Even if I was very concerned about this issue, I could not find much support from the Eurotas board or the Editorial board of the Journal.

Then at the XIV Eurotas conference in Latvia in 2012, during a walk at an open air museum, I spoke with a colleague from Germany, Regina Hess a clinical psychologist, which is also involved in the Eurotas. We were so enthusiastic about our research journey and agreed that research is important to improve clinical practice. We shared also our feeling of concern about the lack of research based practice among many of the people presenting at the meeting. So we conceived the idea of the research division inside Eurotas.

During the meeting we discussed this idea with other two colleagues, one from Greece and the other from South Africa, and decided to create the EDTR to act inside Eurotas toward a research based psychotherapy practice.

For this very difficult and engaging task we found a great support from a colleague on the board of Eurotas that teaches at Sofia University, where research activity is a priority.

As we state in the charter (Appendix 4d page 179): “The specific goal of the EDTR initiative is to promote and expand the body of knowledge and to advance the state of the art of research in the field of Transpersonal Psychology and Psychotherapy, including alternative healing practices. The EDTR follows international ethical guidelines for research and service, with respect for the dignity and worth of human life and rights as a guiding principle.”

I already discussed this study at a symposium organized jointly with Eurotas, ATP and ITP, in Palo Alto (CA, USA) in February 2014 (Appendix 4e page 180).

We are already organizing workshops at international conferences, like the last EUROTAS conference in Greece in October 2014.

At the end of the workshop Marcie Boucouvalas, editor of the Journal Of Transpersonal Psychology, invited me to write an article on the heuristic method applied to clinical studies.

The other article I am writing is more clinical oriented to show the results of this study and it will be published on Integral Transpersonal Journal that is read by Eurotas members and hopefully will stimulate their interest in research applied to clinical practice.

We are also organizing research workshops to be held at different Eurotas institution all over Europe.

The last outcome, which was not intended at the beginning but came from a specific request of some of the clients, is a brochure to explain to the general public BTE methodology as it is described by this study (Appendix 4f page 181).

This has to be considered also from another perspective. In these days people looking for any kind of therapy, either for medical or psychological problems, are actively seeking information about different possibilities. It is therefore important to provide as much information as possible, not just on a theoretical ground but also with practical examples. I think that this study, being based on clinical observation would be clearer and easier to understand and trust.

## EPILOGUE

I would like to end this dissertation with some thoughts about my development as a researcher.

My professional development started as a medical doctor, with a PhD in psychiatry. I always considered human being from a biochemical perspective, my research interest and practice was grounded on quantitative methodology. In the last 15 years, some personal and professional changes made me aware of a transcendental dimension, stimulating a move toward a different approach not only in everyday life, but also in my professional practice. This move would also change my attitude toward research.

For me research now is not only what it used to be following Ramon y Cajal's prescription. The Ego of the "burning desire of reputation" has changed to a desire to share what I might discover with the other in circle.

Now I know that Ramon y Cajal could have been right if we consider science which uses the empirical methods to explain the tangible world.

However, when we come to other dimension, we have to use different mind frame. As Ignazio Di Loyola said:

*"Not the abundance of science will satisfy the soul, but feeling and enjoying things in the heart". (I. Di Loyola, Esercizi spirituali 1967)*

Knowledge is an intellectual process, but it has to come also from the hearth. The first way will lead to understanding and comprehension, the second to feeling and compassion.

As Augustine said:

*"It is not possible to love something which we do not know.  
When we love something that somehow we know, in virtue of this love we are able to know it better and deeper" (Agostino, Si conosce solo ciò che si ama, 2010)*

I see the end of my journey at the Metanoia Institute as a lap of my research journey. Now I can see in front of me a new path in my professional

development, fulfilling my aspiration both as a clinical practitioner, using a psychotherapy approach which takes into account the humanistic and spiritual aspect, and as a researcher, being able to use different approaches to explore human experiences from different perspectives.

In doing so I must remember that each research question starts from me and my own experience. Many times my academic advisor said: “put you into the account”. I’m used to hide behind the pillar of the objectivity of the so called scientific research is based. However with this research journey I realized that the objectivity might deal with the measurement process but it is very difficult, if not impossible, to keep it also in the observation process. It is therefore important not to hide, to make it clear where the observation point is positioned.

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### Appendix 1: BTE dualism map

Conflicting dualism	Tension band	Chakra	Function	Quality	Chronic transe
It is me/I am	Eyes	VII Chakra	Spiritual will. Self-transcendence	Dis-identification	Control: judgement, doubt
To judge/to observe	Oral	VI Chakra	Intuition. Self-transcendence	Awareness	Control: fear, mistrust, need
To hold/to let go	Dorsal	V Chakra	Creativity. Self-expression	Trust	Control: Fear, mistrust, need
Love/hate	thoracic	IV Chakra	Love: forgiveness, compassion. Self-actualization	Forgiveness	Feeling: grudge
To succed/to fail	Diaphragm	III Chakra	Power: emotional control. Self-realization	Personal power	Sensibility: pain, impotence, inability, inadequacy
Pleasure/pain	Stomach	II Chakra	Pleasure: sexuality. Self-assertive	Responsability	Sensibility: pain, pleasure at visceral level
To live/to die	Pelvic	I Chakra	Survival. Self-assertive	Courage	Instinctuality: instability, insecurity

This table summarizes the map of the dualisms. Each dualism can be considered in relation to the tension bands at corporeal level as defined by Lowen and to a chakra level following Chinese medicine. A quality and a psychological function correspond to each level. From the conflicting dualism comes a “chronic transe”. This term identifies a complex behavioural pattern leading to symptoms ranging from psychological stress to psychiatric symptoms.

## APPENDIX 2

### Appendix 2 a Recruitment letter

#### **BIOTRANSENERGETICA – A TRANSPERSONAL PSYCHOTHERAPY.** **A description of BTE practices from a therapist and client viewpoint.**

**Dottoressa Giovanna Calabrese**

**Ph.D. by Professional Study**

**Metanoia Institute, London and Integral Transpersonal Institute, Milan**

The purpose of this study is to describe BTE clinical application. In particular, we want to give a description of the Transe process experience during therapy sessions, from the therapists and clients point of view.

A qualitative research approach, following the heuristic method, described by Moustakas, will be used.

Dr. Giovanna Calabrese will be the Principal Investigator PI. Therapists willing to participate will be considered as co-researchers (therapist-researchers, TR) and must follow the study design and the ethical procedures illustrated below.

In particular, we want to give a therapist and client description of the Transe process experience during therapy sessions.

#### **Study design**

The plan is to consider 7-10 therapists and 15-20 patients. The study is divided into two phases: data collection and analysis.

TR will be in charge of data collection. Each TR will choose 2 to 3 patients to enroll in the study. For each patient and each session TRs will collect the data as described in the tables. All data must be collected in digital format and stored on two different digital media (personal computer and pen drive).

There will be two group meetings between PI and all the TRs. The first such meeting will take place at the beginning of the study to discuss in detail the purpose and procedures, soliciting a group discussion on the meaning of this study for the TRs.

Then for six months, the TR will collect the data as indicated. During these months there will be at least 3 individual meetings between the PI and each of the TRs to discuss what is emerging during the sessions and indwell together in the research topic. TRs will be required to send to the PI the collected material prior to the meeting. These meetings will be audio-recorded and transcribed by the PI.

At the end of the data collection phase, all the data will be transmitted to the PI for the analysis phase. Before starting the analysis there will be another group meeting to discuss what emerged during the data collection and how the heuristic experience was for the TRs.

The analysis will attempt to identify the main themes that characterize the experience of *Transe* from the therapist and client point of view. These themes will be presented by the PI in a creative synthesis.

At the end of the analysis process there will be another group meeting for validation.

The PI will send the synthesis to the TRs and during the group meeting the analysis and

the synthesis will be discussed. If there should be disagreement about the final analysis, the PI will make a revision to present in another meeting. The validation will be completed when group agreement is reached.

### **Code of Ethics**

From the ethical point of view this study has a major issue about not breaking the confidentiality agreement of the therapeutic relationship. It is therefore important that every therapist gain the client's consent to use that part of the clinical information relevant to the study. The therapist has to correctly inform the client about the rationale and methods of the study, and has to ensure the patient anonymity and will not use the data that would somehow allow the direct or indirect identification of the client. The client will be allowed to withdraw his/her consent at any time without explanation and without jeopardizing the therapeutic relationship. In case of withdrawal all data collected will be destroyed and not used for the purposes of the study.

To ensure the anonymity of the data for each patient an alphanumeric code will be used. The number refers to the therapist. Only the therapist will know his/her own number. The letter refers only to the patient and the therapist will be the only one to know the identity of the patient. It is the responsibility of the TRs to delete from the files sent to the PI all the data that could possibly help identify the patient, and when needed disguising them appropriately.

The meeting between the PI and the TRs will be audio-recorded and transcribed by the PI. All this material will be handled anonymously as well.

Another possible ethical concern may be about how Dr. Lattuada may or may not influence the study. Since the therapists involved in the study graduated from Dr. Lattuada's school, to avoid any possible, direct or indirect, influence by him, and allow the therapists to feel free from his possible judgement, he will not be involved in any part of the study and anonymity will be granted to the.

**Appendix 2b: PATIENT CONSENT FORM TO ALLOW THE USE OF  
CLINICAL DATA FOR THE STUDY**

I, the undersigned

---

informed of the aims and methods of the present study give my consent to use part of what will emerge during the sessions for the purposes of the study.

I have been assured that

- My name and no other possible source of identifying information will appear in the material under study.
- The material collected for this study will not be used for purposes other than the present study.
- I am free to withdraw this consent at any time, without giving any explanations and without jeopardizing the therapeutic relationship.
- The collected material will be viewed only by my therapist and Principal Investigator Dr. Calabrese.
- The material will be kept secret and destroyed at the end of the study.

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Patient, Date

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Co- Researcher, Date

## **Appendix 2c: CO-RESEARCHER AGREEMENT TO PARTICIPATE IN THE STUDY**

I, the undersigned

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informed of the aims and methods of this study agree to participate as co-investigator.

- I agree and accept the ethic principles which grant the patient's privacy and confidentiality, with the exception of what he/she would agree to share in the present study, still in full respect of his/her anonymity.

- I am aware that the patient can at any time withdraw his/her coNsent to participate in the study, without need of justification and without endangering the therapeutic relation. In this case I will destroy all the data so far collected.

- I am aware that I will be the only one responsible for the data collected, that I will keep all the data in a digital format, having a back-up, in a safe place, until I am asked for it by the PI (Dr. Calabrese).

- I pledge to work with Dr. Calabrese, the PI of this study, and with the other co-researchers, collecting data and participating in the meetings as directed (one per month).

- I will engage not to divulge in any form the data collected for other studies than the present one, both during the period of this study and in the future.

I will not divulge in any way or form the content of the material collected for this study in any form other than for this study, both during the time course of the present study or in the future.

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Co-researcher, Date

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Primary Investigator, Date

## **Appendix 2d: TRANSLATOR CONFIDENTIALITY AGREEMENT**

I agree to participate as a translator for the study

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I understand that all the texts I will read and translate are subject to confidentiality. I agree not to divulgate them in any way or form other than the published work by the principal author. I understand that the author will acknowledge my translation in any future publication of the data.

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Translator, Date

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Primary Investigator, Date

## APPENDIX 3 - DATA

### Appendix 3a: data collection sheets

Technique used in the session	% of time at session 1	% of time at session 2	% of time at session 3	% of time at session 4	% of time at session 5	% of time at session 6	% of time at session ....	% of time at session n
Body work*								
Mindfulness*								
Others								

**Table 1:** the TRs would follow this scheme to collect data about the % of time they used a BTE practice, indicating also which practice they used and if other practices were used as well.

**Sheet n° 1:** the psychotherapist will report the therapist and patient experience of the Transe, describing the experience on the five levels (physical, emotional, energetic, mental and spiritual). This sheet will be completed at the end of each session.

**Sheet n° 2:** the psychotherapist will report how the patient describes the experiences of the practices at all different levels. This sheet will be completed at the end of each session.

**Sheet 3:** the therapist will report the perception of therapeutic effect of the practices at the end of each session. S/he will also report in general the therapeutic effect of the psychotherapy process after three and six months of therapy. The therapist will report separately his/her impression and the client's impression.

## Appendix 3b: data description

**Table 1: psychotherapists' description with professional profile**

Psychotherapist	Age/gender	Years of practice (others +BTE)	Other approaches
B	60 f	15+ 10	Psychosynthesis
D	58 f	15 + 13	Freudian Psychoanalysis
E	44 f	11 + 7	Transational
F	35 m	7	
H	30 f	6	
R	38 m	6	
X	49 f	3 + 10	Psychiatry
Mean	44	14	

7 psychotherapists (2 males and 5 female) participated to the study. They were coded with a letter; mean age was 44 years. Mean years of practice with BTE was 14 years. 3 of them had also another psychotherapeutic training and one was also a psychiatrist.



**Table 2: clients' description**

<b>Patient</b>	<b>Age/Gender/Education</b>	<b>Duration of BTE/ other therapy</b>	<b>Diagnosis</b>
<b>B1</b>	32/F/u.d.	13 m	
<b>B2</b>	28/F/p.d	11 m	
<b>B3</b>	50/M/u.d.	12 / 5y freudian psychoanalysis	
<b>B4</b>	50/M/p.d.	12 m	Substance abuse (oppioid and alcohol)
<b>D1</b>	45/F/u.d.	30 m/5 y freudian psychoanalysis	Obsessive compulsive disorder
<b>E1</b>	30/F/u.d.	12m	
<b>E2</b>	33/F/ p.d.	9m	Generalized anxiety disorder
<b>F1</b>	25/F/ p.d.	9 m	
<b>F2</b>	30/F/u.d.	9 m	
<b>H1</b>	26/F/ p.d.	12 m /1y Transational	
<b>R1</b>	35/F/ p.d.	9 m	
<b>R2</b>	30/F/u.d.	7 m	
<b>X1</b>	42/M/ p.d.	9m	
<b>Mean</b>	<b>35</b>	<b>11 m</b>	

13 patients (3 males and 10 females) coded with a letter, corresponding to the psychotherapist, and a number, participated to the study. They were all native Italian. Mean age was 35 years. 5 had a university degree (u.d.), the other had a professional diploma (p.d.). Mean duration of therapy with a BTE approach was 11 months. Three of them have had already a previous psychotherapy treatment with other approaches, as indicated.

Three of them had a diagnosis, as indicated. None of them was on drug treatment.

**Table 3: sessions description**

<b>Patient</b>	<b>N° of session using BTE</b>	<b>% of time using BTE practices</b>
<b>B1</b>	<b>4</b>	<b>80</b>
<b>B2</b>	<b>8</b>	<b>80</b>
<b>B3</b>	<b>12</b>	<b>80</b>
<b>B4</b>	<b>11</b>	<b>70</b>
<b>D1</b>	<b>10</b>	<b>50</b>
<b>E1</b>	<b>4</b>	<b>60</b>
<b>E2</b>	<b>4</b>	<b>60</b>
<b>F1</b>	<b>4</b>	<b>80</b>
<b>F2</b>	<b>3</b>	<b>80</b>
<b>H1</b>	<b>24</b>	<b>90</b>
<b>R1</b>	<b>11</b>	<b>70</b>
<b>R2</b>	<b>22</b>	<b>80</b>
<b>X1</b>	<b>4</b>	<b>70</b>
	<b>Total 121</b>	<b>Mean 67</b>

A total of 121 session using BTE practice during a period of six months were considered. The mean percentage of time using BTE practice was 67% of the session time.

**Table 4: practices description**

<b>Practices</b>	<b>Number of time used</b>
<b>4 acknowledgements and MU</b>	50
<b>Transition from 0</b>	25
<b>Captation</b>	71
<b>Psycho-corporal Practices</b>	15

Usually more than one practice was used in the same session, as usually one would introduce the field and the other/s will follow.

**Table 5: therapeutic effect description.**

The patients' and the psychotherapists' description of the psychotherapeutic effect at six months is reported. Outlined are the sentences that somehow describe the same effect, even if with different words. The description was made separately and independently by the patients and the psychotherapists.

	Patient's report of therapeutic effect	Psychotherapist's report of therapeutic effect
<b>B1</b>	I observe my emotions, I do not go away, I stay there, I welcome them, as they belong to me, are part of myself, I allow myself to listen, they talk to me about things that happened or about fears, I listen to them again and again, until they feel they are safe, there is no judging.	I felt a different way of dealing with himself and with its parts, there is acceptance and no struggle any more, nor competition or judgment or fear. I felt like a warm and welcoming maternal side, able to embrace and transform ...
<b>B2</b>	I feel that I have developed basically the ability to see and to move in difficult situations without destroying myself. I have had the experience of "being" and I realized that this is the essence of my being and that all those situations in which I experienced discomfort were coming from a lack of choice and because I was missing a loyalty to my feeling.	He acquired a sense of entitlement and self-importance, leaving away all the forms of labeling and judgment that conditioned his choices and his expressions
<b>B3</b>	When I started the BTE I had little awareness of my emotions and my state and physical space. Then I started to feel and move having greater perception of my body and a greater ability to identify tensions and blockages in me. I understood how my thoughts, both the positive and negative ones, were able to change very effectively my physical and emotional state. My worries and my concerns, unconsciously influenced my movements, such as talking, walking, and being with others. I started to identify old ways of thinking, habits which have become useless. - I started to identify old modalities of thinking, habits, which in time became useless and that I used to face life issues. My mind, used to controlling, especially when I lived with my parents, helped me not to go crazy ... it	He went from moments of strong emotional reaction, accompanied by strong and angry annoyance to his father and to all those situations that could be similar to the father figure, to moments of more harmonious and rewarding situations, that have allowed him to become slowly aware, of his ability, his strength, and especially of his will, which could lead to goals and resolutions of conflicts. One will able to help distinguish the true from the false, and to take note of continuity that has in performing the tasks and responsibilities that you assume.

	<p>gradually stepped aside, allowing trust and joy of life to emerge.</p> <p>On a physical level - I have a greater awareness of my body, how they are made and the parts that make up me.</p> <p>I appreciate my positive aspects and accept my faults.</p> <p>I have learned to take preventive action to avoid the discomfort and channeling the energies in a more constructive and effective way, turning ideas into projects and pleasant things .</p> <p>On the emotional level I started to let go my feelings without judgment with greater understanding and acceptance. My anger and my grudge found a space to move and express themselves but also to resolve.</p> <p>My fear and my anxiety bought one direction and a dimension and have been transformed from simple malaise to information useful to cope with the issues and to make choices .</p> <p>On a mental level , I have learned not to let the thoughts to dominate me, allowing them to act only to the extent that they can be useful and effective .</p> <p>A transpersonal level I noticed in me a greater space to the aesthetic sense of beauty and value . Essentiality of things and the futility of the superfluous , the generosity and the non-attachment to money. The value of respect and sense of ethics . I learned to give more strength to the warrior inside me, in order to take life with greater courage and greater determination, in order to achieve objective and projects that I care about.</p>	<p>This transition involves a detachment from his father's opinions and an ability to stand out in relation to the consideration of himself, taking a position of greater self-worth and esteem and the ability to manifest itself in the roles that he occupies.</p> <p>An integration of anger occurred, even if the need not to feel it sometimes persists.</p> <p>In general, it seems that there is a greater assumption of responsibility in favor of a personal self-assertion</p>
<b>B4</b>	<p>I feel confident and calm and I feel that I can do it well ... and that the worst is over.</p>	<p>He is more able to express his strength and his will. Greater assumption of responsibility in favor of a personal self-assertion.</p> <p>Inside him there are still parts fearful of making mistakes that constantly require confirmation. It 'a father with a good capacity for interaction with his child, knows how to listen and he is even able to accommodate the maternal</p>

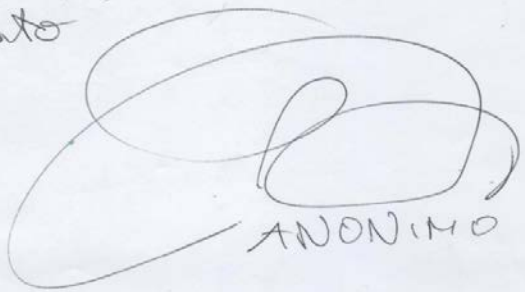
		<p>figure, which died few years ago.</p> <p>It's still too full of theories coming from the numerous courses that he attended.</p> <p>Theories that often prevent him from bringing out his intuition and his ability to perceive what is around.</p> <p>It's a person's soft and comfortable and able to welcome inside himself the outside world, both in relationship with friends and in the relationship with nature.</p>
D1	I feel calmer, relaxed and I feel like I could let go some of the weights.	<p>She looks more balanced, being able to control some serious psychosomatic symptoms that before lead her to the emergency unit. She still needs time to face some personal life event that causes burst of anger towards her relatives.</p>
E1	Regarding myself I listen to myself more; before spending time with my family was a duty, now it has become a pleasure. There's a greater communication with him (boyfriend) than before; when we had fights before I used to think that it was because he did not love me, now I understand that he is not doing well, it doesn't mean that he does not love me enough.	<p>After six months of meetings, she shows greater awareness to take care and responsibility of her projections and of herself. She listens much more to her needs and individuality. Now she seems more aware that there are some aspects about herself worth of consideration, more than the relation to the context (family, relationships, etc.), which has always been a priority for her.</p>
E2	I'm seeing, and this is a little scaring; I started to feel my body and my will, in a way that never happened before, and this is not too bad. Others are bewildered and this is because the real me is coming out, because there are more fights, but I'll take this in a positive way because if this aroused in others, it means to say that I'm going more for what I am .. I don't feel pleasure anymore in things that were rewarding for me before, I feel improved	<p>It seems that more contact with the body and with herself is emerging; she seems to listen more to her needs and her own individuality. Now it seems that she is putting herself at the center of her lives, assuming her responsibilities.</p> <p>She wants to continue the</p>

	<p>What happens to me is to feel my body because I could never put together the mind and body and now I'm picking up more and more myself.. I feel that I have to love myself, I have to be more concentrated about me , and I've given too much importance to the men with whom I have been ..</p>	<p>psychotherapy in order to face some intimate aspects not related to others.</p>
<b>F1</b>	<p>I feel clearer, relieved, comforted. I feel with a clearer head, I am able to take care of myself.</p>	<p>There is a significant improvement in the level of energy that allows a greater stability in all its dimensions.</p>
<b>F2</b>	<p>I feel completely clean, emptied. As if all the bad things, the betrayals, and the tragic things they had not left their mark. They have marked and influenced me all my life, so it's a totally a new thing for me. This is the strongest thing that I feel, as if I wiped them out. And according to me, I was already on this way, with my experience, dreams.. it is as if the treatment had come at the right time, I'd call "</p>	<p>The subject is well. She allows herself to live with greater awareness a different approach to life. He acquired the maps suggested by the therapeutic methodology and integrates them in a synergistic manner with other derived from her sensitivity and other sources met during her life.</p>
<b>H1</b>	<p>I feel more energetic, I want to undertake many activities and express myself through them. Before I always felt inadequate and of little consequence, I always started a thousand things without finishing anything because I did not feel able to finish anything, but now I have started a manufacturing business. I think I can be successful as I am more lucid and able to think by myself I perceive a greater stability of identity, of knowing what I want and to plan my life. I feel more courage. The blocks are less bodily warned: the neck is more fluid , the stomach is felt only occasionally, is also decreasing the craving for food and the night unable to sleep better. On an emotional level , I feel more relaxed , more able to listen to and more courageous in expressing something that I do not agree with. I am sick to be considered and labeled " a calm and sweet ."</p> <p>Through the practices I could catch a glimpse of the possibility to break the framework that makes me think of myself as a fearful and hesitant person , they made me feel free. I am very proud to not try more embarrassment and anger towards the person who had abused</p>	<p>There are still considerable resistances carried out by the patient are considerable. In particular, there is a continuing need to adapt to situations, by suppressing the strong anger that the patient, for now, cannot yet perceive in a defined way. Compared to the beginning of the therapy, the patient feels less afraid to accept the shadowed parts of the self, such as anger, fear of intimacy, emotional closeness, need for approval and the need for recognition. However, considerable progress has been made, particularly with regard to the acceptance of anger at the abuse suffered. Movements have become more fluid, more personalized.</p>

	me, because now I see him for what he is: a fragile person , to which , however , if there is the case, I will not hesitate to express openly my hatred.	
<b>R1</b>	I recognize some times when I am in contact with my strength, I recognize I can be present in a different way.	I feel a loose grip within the therapeutic relationship. But I am glad that despite this, she decides to get back into the game in the first person actively participating to the sessions.
<b>R2</b>	To me it's not easy to quit picking up the crumbs from the table where the nobles are sitting and sit down at dinner table with them, a noble. I am confused and I still feel a part of myself that resists while sitting at the table of the nobles.	It is very nice to see her rattle off all possible ambushes and experiences related to the choice she wants to make for her own life and see the progress of the consciousness behind it. I feel that it is important that she begin to recognize the feelings and understand her inner processes in which she plunges. It's still amazing how things happen by themselves just following what emerges.
<b>X1</b>	I feel more liberated conscious and quiet. Memories of past episodes and thoughts that keep me awake the night of the session ... I saw my life past and present and put it back in order with the new way of seeing things.	It seems more confident, less compliant to be overwhelmed by others. The mimicry is more mobile, and congruent with the emotional contents; the sight is more direct. The symptoms he had come for seem almost forgotten, is now more focused on his social life and the ability to operate personal choices.



Cara Dott.<sup>ssa</sup> Giovanna,  
Il comitato dei pazienti, da me  
qui rappresentato, la ringrazia  
per aver fornito un ottimo  
strumento di feed-back, altrimenti  
sottovalutato.



ANONIMO ♥

**Figure 1:** this letter was written by one of the patient at the end of the study. It says:  
“Dear Dr. Giovanna, on behalf of all the patients, I would like to thank you for  
providing a valid feedback tool, rather underestimated.”

## APPENDIX 4 – RESEARCH OUTCOMES

### Appendix 4a: book publication

#### *THE HEALING FIELD*

##### Contents

Historical introduction:      The therapeutic setting  
   The therapist  
   The patient

In this introduction I will describe the evolution of these three areas of the therapeutic process: the context, or setting, the therapist and the patient. The setting will be considered in its evolution from sacred space, referring to both the Aesculapius cave in ancient Greece, considered the origin of western culture, and the sciamanic culture from different countries, to arrive at the actual techno-scientific area of knowledge, expression of the modern western medicine. In this excursus the psychotherapy field will be considered as well.

Biotransenergetica Introduction:      Disease or chronic Transe  
   The healing process as psycho-spiritual  
   evolution

In this section the epistemological and scientific assumptions of Biotransenergetica approach will be discussed, in reference to both the psychodynamic and therapeutic methods, based on non-ordinary state of consciousness will be described.

Clinical study: The meaning of the Transe in the therapeutic process

In this section the study conducted with the psychotherapist and the clients will be discussed.

The present project for a book as been accepted for publication by Integral Transpersonal Institute Ed.

**Appendix 4b: conference at the A.O. G. Salvini, Garbagnate Milanese, Milan  
(Italy)**

In the following pages the program of the educational event already held in Garbagnate Milanese (Milan, Italy) is shown. The same conference is scheduled in other hospital with the same format.



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Resp. Dott.ssa M.R. Monaco

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**BIOTRANSENERGETICA – UNA PSICOTERAPIA TRANSPERSONALE**

**Description of the methods of BTE**

**according to the lived experience of the therapists and clients**

Dottorssa Giovanna Calabrese

Integral Transpersonal Institute, Milano

**PURPOSE OF THE INITIATIVE:**

Transpersonal psychology proposes an approach to psychotherapy that takes into account spiritual instances in the development of the person and in the therapeutic process. Although it is present on the cultural scene since the 60s, is not very well known in the clinical field.

The purpose of this conference is to promote greater knowledge of transpersonal psychology, illustrating the Biotransenergetic (BTE) as an approach of transpersonal psychotherapy. The BTE founded by Pierluigi Lattuada, medical doctor specialized in clinical psychology, and Marlene Silveira psychologist, is present in Italy since the 80's. Since 2002 the Training School in Transpersonal Psychotherapy, directed by Lattuada has been approved by the Ministry of Research and Education.

**TITLE:**

Biotransenergetic – A Transpersonal approach to psychotherapy. Description of the methods according to the lived experience of the psychotherapists and patients.

**EDUCATIONAL EVENT:**

It has been several years that students from the School of Education in Transpersonal Psychotherapy in Milan, directed by Dr. Pier Luigi Lattuada, are engaged in residency training at this Department. The objective of the conference is to share with colleagues in the service the knowledge of transpersonal psychotherapy in general and BTE in particular. The conference is also addressed to trainees and students of psychology and psychotherapy.

**CONTENTS / TOPICS:**

Theory and clinical applications of transpersonal psychology.

Illustration of a clinical study using qualitative method on the clinical application of the BTE methodology.

**DATE:**

14<sup>th</sup> of March, 2014

**PROGRAM / DURATION event:**

The conference will last 2 hours. In the first part transpersonal psychology and psychotherapy approach as well as Biotransenergetic will be presented.

Afterward, a study on the clinical application of the BTE, conducted in a clinical setting with a qualitative method according to a heuristic approach, will be presented.

At the end there will be a discussion with participants on the arguments presented.

**ORGANIZATIONAL OUTCOME**

Expand the knowledge in the field of transpersonal psychology and psychotherapy, with a special focus on a spiritual approach to help both patients and practitioners to deal with dying, considering that in our hospital there is a hospice and an Oncology Department.

#### **Appendix 4c**

#### **Evaluation Questionnaire of the Conference at the A.O. G. Salvini, Garbagnate Milanese, Milan (Italy)**

Participants were asked to fill the evaluation form reported in the following pages.



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**Servizio di Psicologia Clinica**

Resp. Dott.ssa M.R. Monaco

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**EDUCATIONAL EVENT**

**BIOTRANSENERGETICA**

**UNA PSICOTERAPIA TRANSPERSONALE**

**Description of the methods of BTE according to the lived experience of the psychotherapists and the clients**

**Dottoressa Giovanna Calabrese  
Integral Transpersonal Institute, Milano**

**Event evaluation questionnaire**

I would like to know your opinion about this event, would you please answer to the following questions:

1) Did you already know transpersonal psychology and psychotherapy?

NO YES

If you answered yes, where did you learn about it?

- During your university education
- During your psychotherapy training
- Others

2) Did you already know about Biotransenergetica?

NO YES

If you answered yes, where did you learn about it?

- During your university education
- During your psychotherapy training
- Others

3) Did you already know about qualitative research methods?

NO YES

If you answered yes, where did you learn about it?

- During your university education
- During your psychotherapy training
- Others

If you answered yes, which methods do you know? \_\_\_\_\_

- How would you rate from 0 (not at all) to 7 (a lot) this event as useful for your professional education?
- What do you think it was lacking in the presentation?
- Do you have any suggestions on how to improve it?

Thank you for attending and for your cooperation, Giovanna Calabrese



#### **Appendix 4d**

##### **Eurotas Division of Transpersonal Research (EDTR) - Charter**

This project started as part of my involvement in qualitative research applied to explore the transpersonal psychotherapy field.

# **EDTR CHARTER – ADDENDUM TO THE EUROTAS BYLAWS**

## **●A. Goal and Objectives:**

The specific goal of the EDTR initiative is to promote and expand the body of knowledge and to advance the state of the art of research in the field of Transpersonal Psychology and Psychotherapy, including alternative healing practices. The EDTR follows international ethical guidelines for research and service, with respect for the dignity and worth of human life and rights as a guiding principle.

## **●B. Ethical Principles**

The EDTR functions on the principles of The EUROTAS Committee for Certification and Accreditation (ECCA) as adopted from the European Association for Psychotherapy (EAP). The EDTR further subscribes to international principals for ethics in research such as of the American Psychological Association (APA), British Psychological Association, Ethical Guidelines for Field Research (Watkins, Pacifica Graduate School, U.S.), and Stellenbosch University Research Ethics, South Africa.

It provides a function of ethical review and support for research done in the field of Transpersonal Psychology. Comprehensive EDTR Ethical Review procedures and documents are available on the EDTR Weblink. The core ethical guidelines are summarized below by referring to, acknowledging and adapting the above mentioned references:

Transpersonal Researchers respect the dignity and worth of the individual and strive for the preservation and protection of fundamental human rights. They are committed to increasing knowledge of human behavior and of people's understanding of themselves and others and the utilization of such knowledge for the promotion of human welfare. While pursuing these objectives they make every effort to protect the welfare of research participants and those who seek their services. While demanding for themselves freedom of inquiry and communication, Transpersonal Psychotherapists accept the responsibility this freedom requires.

In the pursuit of these ideals, Transpersonal researchers also honor ethical principles in the following areas:

1. Responsibility;
2. Competence;
3. Moral & Legal Standards;
4. Confidentiality;
5. Welfare of the Consumer;
6. Professional Relationships;

- 7. Public Statements;
- 8. Assessment Techniques;

Researchers in Transpersonal Psychology maintain high standards of scholarship by conducting research according to rigorous scholarly principles. They accept responsibility for the selection of their research topics, methods, analysis and reporting. They clarify in advance with all appropriate persons and agencies the expectations for sharing and utilizing research data and interference with the milieu in which data are collected is kept to a minimum. The maintenance of high standards of competence is a responsibility shared by all researchers. Transpersonal researchers act according to the principles of EAP and their National Awarding Organization's (NAO) and their institute or association's standards and guidelines related to practice and research, including institutional and governmental laws and they also promote socially relevant research. They are sensitive to issues of (but not limited to) race, disability, age, gender, sexual preference, and religion. Researchers respect confidentiality and only conduct research with participants who have granted informed consent to the research. Provision is made for maintaining confidentiality in the storage and disposal of research. Special care is taken in studies done with minors or other persons who are unable to give voluntary, informed consent, to protect their best interests. Risk/benefit issues for participants are carefully considered and a clear and fair agreement with research participants is established, prior to their participation. The investigator respects the individual's freedom to decline to participate in or withdraw from the research at any time. The investigator protects the participant from physical and mental discomfort, harm, and danger that may arise from research procedures. Transpersonal researchers respect and take into account the client's experiences with archetypal, mythical, paranormal, mystic, spiritual and religious contents and are aware of the high sensitivity and openness associated with the client's state of consciousness. (EUROTAS Committee for Certification and Accreditation (ECCA) Freiburg, February 2006). Consent obtained from the participant does not limit their legal rights or reduce the investigator's legal responsibilities. Research funding is managed in an ethical manner and research relationships with co-researchers and/or participants are not exploited. Publication credit is assigned to those who have contributed to a publication in proportion to their professional contributions. All contributors are acknowledged and named. In conducting research in institutions or organizations, researchers secure appropriate authorization to conduct such research. They are aware of their obligation to future research workers and ensure that host institutions receive adequate information about the research and proper acknowledgments of their contributions. The limits and uncertainties of such evidence is recognized. The investigator always retains the responsibility for ensuring ethical practice in research.

#### ●C. Executive Sponsors:

European Transpersonal Association as umbrella of EDTR.

●D. EDTR Team

**Core Team (C) & Support Members**

<b>Names of Member</b>	<b>Area of specialization</b>	<b>Affiliation</b>
<b>Giovanna Calabrese, M.D., Ph.D. (C)</b>	<b>Health care and neuroscience, psychotherapy</b>	<b>Eurotas board of directors Integral Transpersonal Institute (Psychotherapy school recognized by MIUR-Italy)</b>
<b>Regina U Hess Ph.D. (C)</b>	<b>Psychotherapytraditional healing practices, bridging arts &amp; sciences</b>	<b>Eurotas board of directors Psychologist, psychotherapist Arts &amp; Sciences Researcher Forum, University of Cambridge, UK</b>
<b>Lindy McMullin Ph.D. Cand., (C)</b>	<b>Transpersonal Psychology- Psychotherapy Quantum Field Therapy</b>	<b>Stellenbosch University, S. Africa Synthesis, EUROTAS</b>
<b>Rona Newmark Ph.D., (C)</b>	<b>Psychology, psychotherapy Community Interaction, Quantum Biofeedback, Rohun Therapy Hypnotherapy</b>	<b>Associate Professor in Educational Psychology, Stellenbosch University Psychologist in Private Practice</b>
<b>Support Member: Pier Luigi Lattuada M.D. Ph.D.</b>	<b>Psychology, Psychotherapy Shamanism</b>	<b>Eurotas Co-Vice President Integral Transpersonal Institute (Psychotherapy school recognized by MIUR-Italy)</b>
<b>Support Member: Steven Schmitz Ph.D.</b>	<b>Shamanism, Transpersonal psychology</b>	<b>Eurotarotas Board Secretary Co-President of ATP Sofia University, USA Lecturer, Shamanic Healing</b>

### ●E. Scope of Effort In (Scope and Out of Scope):

There are publications on altered state of consciousness and about spirituality in psychology. However, this knowledge mostly does not go beyond the Transpersonal field. Mainstream psychology and academic medical systems, which are in control of the health care system, often ignore Transpersonal Psychologists. The Transpersonal movement is missing the opportunity to claim their place in the health care system and mainstream science.

Transpersonal practitioners and scientists have to know how to communicate with the systems, and they also have to demonstrate the validity of their practices. It is a field that requires research and publications in indexed journals. The goal of EDTR is to facilitate this process for EUROTAS members, through activities described in more details in section E

The scope of EDTR actions includes working on the scientific base of Transpersonal practices and Transpersonal psychotherapy through conducting research, researcher training, conferences, and diverse publications for EUROTAS.

EDTR will provide a service of support and supervision for research projects conducted through EUROTAS members, EDTR will create an “Ethics Review Committee” where research proposals could be reviewed.

### ●F. Output: Team Responsibility of EDTR and Output

Initially, we propose work at three different levels:

#### **1 Diffusing knowledge about research methodologies and methods among students and practitioners in the Transpersonal field.**

**A)** We will organize workshops on research methods. These may be contact sessions and/or on a web-format.

We will apply for accreditation of these workshops by major institutions affiliated with Transpersonal Psychology, such as the Integral Transpersonal Institute in Milan (Italy) and Sofia University (USA), and others.

**B)** We will organize focus group discussions during the EUROTAS meetings to promote research in different areas of Transpersonal Psychology and psychotherapy, such as altered states of consciousness, re-birthing, and other healing practices that are often not integrated into mainstream psychotherapy and psychology schools.

#### **2 Disseminating knowledge of transpersonal psychology and research for a wider**

**audience.**

**A)** One avenue of outreach to a more general public might be through creative approaches to interpretative/expressive research findings, with links to the field of performance sciences such as art, film, theater, music and community events.

**B)** To reach an academic audience we will try to organize seminars in Universities, or Hospital/health care facilities to present Transpersonal psychology and psychotherapy

**3 Networking and organizing professional and academic exchanges in different countries and different institutions**

**A)** Providing expert help for research projects of independent researchers, organizations, academic teaching, curriculum development and social/cultural outreach to Transpersonal communities.

**B)** Forming specific delegations on Transpersonal research at international conferences so that presence of EUROTAS is extended.

**●G. Requirements: For the team to operate effectively, it will need the following:**

EDTR will need electronic contact lists of students/affiliations of Transpersonal schools/associations within the EUROTAS community

EDTR will need to collaborate with EUROTAS conference organizers to have a EDTR open sessions e.g. round table researcher discussion to further initiate research projects and collaboration such as establish a “Researcher Café” discussion forum.

EDTR will need to work with external expert help, particularly for the Ethics committee and the different research methodologies.

**●H. Key Issues: The team has identified these key issues which will need to be addressed during the planning phase:**

Issues

Resolution

**Inside EUROTAS**

**Workshops on Research**

Sessions at conferences

Seminars at different EUROTAS Institutions

**Outside EUROTAS**

**Networking**

Experts on research and collaboration  
with ethics committees

**Publications**

●**I. Assumptions: The team will operate under the following key assumptions:**

EDTR is voluntary work.

Participation to meetings/conferences will be at our own expenses.

When research workshops will be conducted through EDTR, a fee will be charged to cover expenses and to remunerate the organizer.

If there is a profit 30% of the net profit fee will go to EDTR for EDTR fund for future events or expenses.

●**J. Status**

A Standing Team of the Core EDTR Members G. Calabrese, R. Hess, L. McMullin, and R. Newmark approved by the EUROTAS board in February 2013.



## **Appendix 4e**

### **International Symposium in Palo Alto, February 2014**

I presented the Heuristic method of research applied in clinical study at the “Global Transpersonal Symposium” in Palo Alto. The symposium was co-hosted by ATP, Eurotas, ITP and Sofia University.

The method developed to apply heuristic research in clinical studies raised interest in the audience, in particular for the possibility to study inner experiences from a psychotherapeutic perspective.

# CERTIFICATE *of* PRESENTATION

*This certifies that*  
**GIOVANNA CALABRESE, MD**

*Has presented on the Panel for Transpersonal Research*  
*"Heuristic Inquiry as a Method for Clinical Study in Transpersonal Psychotherapy"*  
**2014 Global Transpersonal Symposium**  
*co-hosted by The Association for Transpersonal Psychology (ATP)*  
*and Sofia University, Palo Alto, CA, USA*  
*with the European Transpersonal Association and the International Transpersonal Association*

February 8, 2014

DATE

*Steven Schmitz, Ph.D.*  
ATP CO-PRESIDENT

## **Appendix 4f**

### **Patients infos**

The idea for this text came from a request made by some of the clients participating to the study, which were willing to know the results of the study.

This text has been published on the BTE web site

(<http://lnx.biotransenergetica.it/files/ricerca/ricerca%20BTE%201.pdf>) as information for the general public, either clients or patients or people interested to enroll in the Transpersonal Psychotherapy Program.

This text will also be used for the annual application at the Ministry of Education and Research for the accreditation of the School as a Psychotherapy Master program.

“The following conceptual and structural boundaries are based on a clinical study conducted on 7 psychotherapist and 13 patients, with a total of 121 clinical session examined. The study was focused on the psychotherapist and the patients description of the Transe process during the psychotherapy session. Aim of the study was to understand how the Transe works to the therapeutic effect and self-development. From the conceptual perspective, the Transe, that is the field of non-ordinary state of consciousness, allows integration of the five levels, physical, emotional, mental, energetic and spiritual, to occur. At the same time a process of dis-identification from the mental and emotional contents might happen. These two effects allow the therapeutic process to develop through two different ways. Either the so called primary cycle of observation-acceptance-awareness or the secondary cycle of contact-mobilization-direction-transformation to occur.

This therapeutic process would lead to a subjective state of well being, improving awareness about inner mechanisms, both on the mental and the emotional levels. It was also reported an improving of self listening and also listening to others' emotion, leading to more satisfying relationships.

As far as the structural boundaries are concerned, the psychotherapeutic relationship in BTE is based mainly on the observation and listening by the psychotherapist, which shares with the patient the therapeutic field, completely, even at a physical level. No interpretation or cognitive elaboration of the mental and emotional contents have place during the therapeutic session

The body plays an important role in the therapeutic process. In fact, through the body the other levels can express or can be explored. This can happen either by observation and listening or by movement and touches.”